

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *231*

12698

### 1. PLACE OF DEATH:

County *Prince Georges*  
City or town *Cherry Hill*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *Permanent death on arrival*  
Hospital, institution, or street address where death occurred:  
*Prince Georges General Hospital*  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State *Maryland* County *Prince Georges*  
City or town *Springfield Md*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

*Peter C. Alamia*

### 3. (b) Social Security Number

#### 4. Sex

*Male*

#### 5. Color or race

*White*

#### 6. (a) Single, married, widowed, or divorced

*Married*

#### 6. (b) Name of husband or wife

*Elizabeth O. Alamia*

#### 7. Birth date of deceased (mo., day, yr.)

*Nov 14, 1907*

#### 6. (c) If alive, give age, years

*36*

#### 8. AGE:

*46*

Years

Months

Days

If less than one day

hrs.

min.

#### 9. Birthplace

*Brownsville Texas*

#### 10. Usual occupation

*Telephone operator*

#### 11. Industry or business

*Regiment Veterans Adm.*

#### FATHER

##### 12. Name

*Texas*

##### 13. Birthplace

*Texas*

#### MOTHER

##### 14. Maiden name

*unknown*

##### 15. Birthplace

*Texas*

#### 16. Informant

*Elizabeth O. Alamia*

##### Address

*Springfield Md*

#### 17. Burial

*Dec 8, 1948*

#### (Burial, cremation, or removal. Which?)

*Arlington Cemetery*

##### Cemetery or crematory

##### Location

*Arlington Va*

#### 18. Funeral director

*F. Kischka sons*

##### Address

*Hyattsville Md*

#### 19. Date rec'd by registrar

*Dec 6 48*

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 5, 1948* at *6:45 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

#### Immediate cause of death

*Coronary Occlusion*

#### Due to

*Cardio-vascular renal disease*

#### Due to

#### Other conditions

(Include pregnancy within 3 months of death)

#### Major findings of operations

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

#### Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

#### Means of injury

Injured at work?

#### 23. SIGNATURE

*John J. Maloney*

Deputy Medical Examiner

M. D. or other

Address *Cherry Hill Hyattsville Md* Date signed *12-5-48*

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

245

1. PLACE OF DEATH:

County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
4300 Jefferson Street,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Prince Georges

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4300 Jefferson Street,

(If rural, give LOCATION)  
none

2.(a) If veteran, name war

3. (a) FULL NAME

THOMAS KNOX BANKS

3. (b) Social Security Number

174-01-0248

4 Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Isabel E. Banks

7. Birth date of deceased (mo., day, yr.)

April 25th, 1882

6. (c) If alive, give age

57

years

8. AGE:

Years

Months

Days

If less than one day

66

8

2

hrs.

min.

9. Birthplace

England

(Town, county, and state)

10. Usual occupation

Engineer (Stationary)

11. Industry or business

Woodward & Lothrop Dept. St.

FATHER  
MOTHER

12. Name

Thomas Banks

13. Birthplace

England

14. Maiden name

Jane (Unknown)

15. Birthplace

Ireland

16. Informant

Mrs. Isabel E. Banks

Address

4300 Jefferson St., Hyattsville, Md.

17

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 31st, 1948

(month) (day) (year)

Cemetery

XXXXX Buffalo Burial Park Asso.

Location

Tonawanda, New York

18. Funeral director

W.W. Chambers Company

Address

5801 Cleveland Ave., Riverdale, Md.

19.

(Date rec'd by registrar)

1948

James Severy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

12-21

1948

at 24

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Acute Coronary  
Sclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Acting Deputy Medical Examiner

Address

Hyattsville, Md.

Date signed

12/27

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12700

Reg. Dist. No. *245*

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town College Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yearHospital, institution, or street address where death occurred:  
4624 Knox Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town College Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4624 Knox Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ellwood Theodore Bauman

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Imogene Bauman6. (c) If alive, give age 35 years7. Birth date of deceased (mo., day, yr.) February 27, 1898

## 8. AGE:

Years

Months

Days

If less than one day

50910

.....hrs. ....min.

9. Birthplace New York City

(Town, county, and state)

10. Usual occupation Financial Advisor11. Industry or business U.S. Veteran's Administration

## FATHER

12. Name Henry C. Bauman13. Birthplace Germany

## MOTHER

14. Maiden name Garr15. Birthplace Pennsylvania16. Informant Imogene BaumanAddress 4624 Knox Rd., College Park, Md17. Burial Date thereof Dec 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington CemeteryLocation Arlington Va18. Funeral director E. Gasch's sonsAddress Hyattsville, Md19. Dec 13 1948 James Seay  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1948 at 7.20P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
.....19..... to .....19.....

and that I last saw him .....alive on .....19.....

## Immediate cause of death

Coronary Occlusion

## DURATION

Due to Cardio-vascular renal disease.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address Chesley, Md Date signed 12-10-48

Deputy Medical

Examiner

M. D. or other

**RECEIVED**

DEC 14 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *12701* *245*

### 1. PLACE OF DEATH:

County *Bryce Georges*  
City or town *Brentwood Md.*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State *Md.* County *Prince Georges*  
City or town *Brentwood*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *8711 Cherry St.*  
(If rural give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

*William Henry Bollinger*

### 3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Widowed*

6.(b) Name of husband or wife *Effie Estelle Bollinger*

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept 10, 1863*

8. AGE: Years *85* Months *5* Days *1* It less than one day *hrs. min.*

9. Birthplace *Pa.*  
(Town, county, and state)

10. Usual occupation *Retired*

11. Industry or business *Western Md. Railroad*

12. Name *George S. Bollinger*

13. Birthplace *Pa.*

14. Maiden name *Elizabeth Road*

15. Birthplace *Pa.*

16. Informant *Ray Bollinger*

Address *Brentwood Md.*

17. Burial *Burial* Date thereof *Dec 6, 1948*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Mt Zion Lutheran Cemetery, Frederick Co. Maryland*

Location *F Gasche home*

18. Funeral director *Hyattsville Md*

Address *1000 5th Avenue*

19. *Dec 6 1948* Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 3, 1948* at *8:40 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1948* to *Dec 3, 1948* and that I last saw him alive on *Dec 3, 1948*

Immediate cause of death *Myocarditis*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *John Hays* M. D. or other

Address *Hyattsville Md.* Date signed *12-4-48*

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 8 1948

BUREAU T. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12702  
231

### 1. PLACE OF DEATH:

County Prince George's  
City or town Chesley, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 min.  
Hospital, institution, or street address where death occurred:  
Prince George's General Hospital  
How long in hospital or institution? 30 min.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince George  
City or town Colmar Manor, Brentwood, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3807 Keary Road  
(If rural, give LOCATION)

2.(d) If veteran, name war

### 3. (a) FULL NAME

Bolsinger, Baby Girl

### 3. (b) Social Security Number

4. Sex F. 5. Color of race W. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 28, 1948

8. AGE: Years Months Days If less than one day  
hrs. 30 min.

9. Birthplace Prince George's General Hospital  
(Town, County, and State)

10. Usual occupation

11. Industry or business

12. Name Bolsinger, George

13. Birthplace Pa.

14. Maiden name Hoessman, Anna

15. Birthplace Mayland

16. Informant

Address

17. Cremation Date thereof 1/1/49  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium Prince George's General Hospital

Location Chesley, Md.

18. Funeral director A. T. Brasley, Supt.

Address Chesley, Md.

19. 1/4 49 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1948 at 8-P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Atalactasis

Due to Pruniverty

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis Warner MD

Address

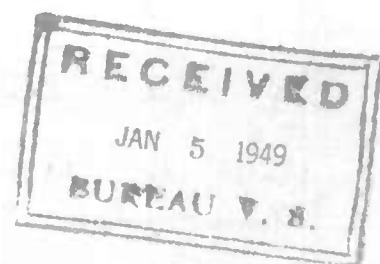
Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for info. added  
to # 22 is on:  
Film No. G119 2/11/49

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12743  
231

### 1. PLACE OF DEATH:

County Prince Georges Co  
City or town 49th St. Bladensburg, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Transient  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Prince Georges  
City or town Bladensburg, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Maggie Bowden

### 3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6. (a) Single, married, widowed, or divorced single

8. (b) Name of husband or wife \_\_\_\_\_

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) ? ABT. 1908

8. AGE: Years 40? Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace North Carolina  
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business \_\_\_\_\_

12. Name Earl Bowden

13. Birthplace N.C.

14. Maiden name Francis Harris

15. Birthplace N.C.

16. Informant Mrs. Francis

Address Rich square North Carolina

11. (Burial, cremation, or removal? Which?) transportation Date thereof Dec 20, 1948  
(month) (day) (year)

Cemetery or crematory Rich square

Location North Carolina

18. Funeral director F. Busche song

Address Hyattsville Md.

19. 12/20 19 48 Amanda Downey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death wife held pending  
pathological report on blood

DURATION

Due to Acute alcoholism

Due to (2/10/49 G.S.)

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results wife held pending

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thomas A. Christensen Seal

Address Coalgate Park, Md. Date signed 12/19/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

DEC 21 1948

BUREAU V. S.

*Handwritten notes:*  
1000 ft.  
1000 ft.  
1000 ft.  
1000 ft.  
1000 ft.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

### 1. PLACE OF DEATH:

County Pr. George  
City or town Chesley, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Dec. 8 - 1948  
Hospital, institution, or street address where death occurred:  
Pr. George General Hosp  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George  
City or town Brentwood Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3708 Gungy st  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

George Boyce

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Ethel F. Boyce  
7. Birth date of deceased (mo., day, yr.) August 9, 1885 6.(c) If alive, give age 53 years  
8. AGE: Years 63 Months Days If less than one day hrs. min.

9. Birthplace Washington D.C.  
(Town, county, and state)  
10. Usual occupation Businessman  
11. Industry or business Government Printing Office  
12. Name Edwin H. Boyce  
13. Birthplace Washington D.C.  
14. Maiden name Rhoda K. Brown  
15. Birthplace Washington D.C.  
16. Informant Robert Grey  
Address Mt Rainier Md.

17. Burial Date thereof Dec. 8 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Fort Lincoln Cemetery  
Location Belmar Manor, Md. P.O. Box 60  
18. Funeral director William J. Talley  
Address 3200 - R.I. Ave. Mt. Rainier, Md.  
19. Dec 9 1948 James Berry Registrar  
(Date rec'd by registrar)

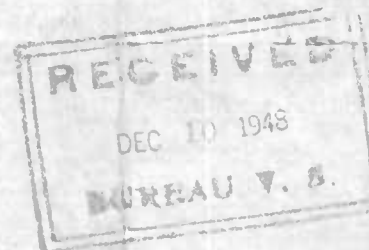
### MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1948 at 9:00 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19  
and that I last saw him alive on 19  
Immediate cause of death Coronary Occlusion  
Due to Cardio-vascular renal disease  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE John D. Maloney, M.D.  
Address Chesley - Maryland Date signed 12-6-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12705

164C

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Suitland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 1/2 years  
 Hospital, institution, or street address where death occurred  
4215 Spring Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Suitland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4215 Spring Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Wilmer Theodore Brightwell

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

male

## 6. (b) Name of husband or wife

Lee Echel Brightwell

## 7. Birth date of deceased (mo., day, yr.)

May 3, 1918

## 6. (c) If alive, give age

28 years

## 8. AGE:

Years

Months

Days

If less than one day

36

hrs.

min.

## 9. Birthplace

Allentown, Maryland  
(Town, county, and state)

## 10. Usual occupation

mechanic

## 11. Industry or business

Automobile

## FATHER

## 12. Name

Eloze Brightwell

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Myrtle Barrett

## 15. Birthplace

Maryland

## 16. Informant

Mrs Lee Echel Brightwell

## Address

Suitland, Maryland

## 17. (Burial, cremation, or removal, Which?)

Burial

## Date thereof

Dec. 21-48  
(month) (day) (year)

## Cemetery or crematory

Arlington National Cemetery

## Location

Arlington, Va

## 18. Funeral director

Arthur E. Simmons

## Address

2007 Nichols Ave. S.E.

## 19.

Dec. 17-  
(Date rec'd by registrar)19 48Edna F. Collins  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

December 17, 1948 at 5:45 P  
M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h..... alive on

19

## Immediate cause of death

Hemorrhage and shock  
Due to gun shot wound through chest  
Due to

## DURATION

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Suicide Date of 12-17-48

Where did injury occur?

Suitland

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?)

HomeMeans shot self with 27 rifleIs there any other work? no

## 23. SIGNATURE

James J. Boyd

M. D. or other

Address

Forestville MdDate signed 12-17-48

RECEIVED

DEC 27 1948

BUREAU V. D.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 137362

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Rosaryville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Rosaryville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war No

## 3. (a) FULL NAME

PHILLIP BROWN

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Laura Brown7. Birth date of deceased (mo., day, yr.) ? ? 1879 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 69 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Charles Brown13. Birthplace Maryland14. Maiden name Annie Gordon15. Birthplace Maryland16. Informant Mr. Phillip M. BrownAddress Washington, D.C.17. Burial Date thereof 12 16 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy RosaryLocation Rosaryville, Maryland18. Funeral director Ritchie Bros.Address Upper Marlboro, Maryland19. Dec 15 19 48 R. G. Smith  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Tues. Dec. 14th 19 48 at 12:30 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Dec 1948 to 14 Dec 1948 and that I last saw him alive on 10 Dec 1948Immediate cause of death Generalized atherosclerosisDURATION 2 wk

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

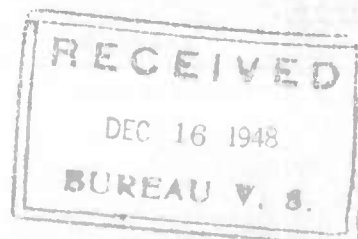
23. SIGNATURE R. G. Smith M. D. certifierAddress Upper Marlboro, Md Date signed 15 Dec 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince George  
City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 25 days  
Hospital, institution, or street address where death occurred:  
Prince George General  
How long in hospital or institution? 25 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Prince Geo  
City or town Riverview MD  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4810 Karenwood Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war none

### 3. (a) FULL NAME

Elmer P Calvin

### 3. (b) Social Security Number

C

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Edith Calvin

7. Birth date of deceased (mo., day, yr.) May 12, 1861 6.(c) If alive, give age 66 years

8. AGE: Years 87 Months 6 Days 18 If less than one day  
hrs. min.

9. Birthplace Indiana  
(Town, county, and state)

10. Usual occupation retired

11. Industry or business Contractor

12. Name Ira Calvin

13. Birthplace Indiana

14. Maiden name Pangburn

15. Birthplace Indiana

16. Informant E.E. Catrin

17. Address 5806-42 Ave Hyattsville Md.

18. Burial Date thereof Dec 3, 1948  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St Lincoln

Location Colman Manor Md

18. Funeral director F. Koeche soys

Address Hyattsville Md

19. Dec 2, 1948 Amanda Downey Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1 1948 at 22 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1948 to 12-1 1948

and that I last saw him alive on 11-30 1948

Immediate cause of death Cerebral haem. DURATION 6 hrs

Due to Hypertensive 10 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leonard Hays M. D. overrider

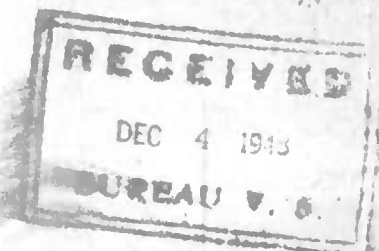
Address Hyattsville Md Date signed 12-1-48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 105

Reg. Dist. 24-0

### 1. PLACE OF DEATH:

County Pr. Geo.

City or town Rural, Croon, Ind.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Pr. Geo.

City or town Rural - Croon  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1/4 mi. west  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Rose Anna Chase

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Andrew Chase

8.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) June 1, 1902

8. AGE: Years 46 Months 5 Days 19 If less than one day  
hrs. min.

9. Birthplace Brownsburg, P. S. Ind.  
(Town, county, and state)

10. Usual occupation Prof.

11. Industry or business

12. Name McLean Booth

13. Birthplace Brownsburg Ind.

14. Maiden name Fannie Smith

15. Birthplace Brownsburg Ind.

16. Informant Andrew Chase

Address Upper Marlboro, Ind.

17. (Burial, cremation, or removal, Which?) Buried Date thereof 12-23-48  
(month) (day) (year)

Cemetery or crematorium St. Carmel

Location Upper Marlboro Ind.

19. Funeral director Waldorf & Gray

Address Waldorf Ind.

19. (Date rec'd by registrar) 12/21/48 Registrar M. L. Howard

Dec. 23/48 F. A. Billingsley

### MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Dec 19 48 at 2:30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 Dec 19 48 to 21 Dec 19 48

and that I last saw her alive on 20 Dec 19 48

Immediate cause of death Cerebral Vascular Accident

DURATION 16 hrs

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Jarner M. D.

Address Upper Marlboro Ind. Date signed 21 Dec 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County... Prince Georges  
 City or town... Glenn Dale, Md. (RURAL)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs., 3 mo.s., 13 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 3 yrs., 3 mo.s., 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... D.C. County...  
 City or town... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 2121- 15<sup>th</sup>, N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

LUCINDA COLLINS

## 3. (b) Social Security Number

577-34-9444

4. Sex... Female  
 5. Color or race... White  
 6.(a) Single, married, widowed, or divorced... widowed  
 6.(b) Name of husband or wife... Samuel Arvil  
 6.(c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.)... June 12, 1911  
 8. AGE: Yeara... 37 Montha... 6 Daya... 19 If less than one day... hrs. min.

## MEDICAL CERTIFICATION

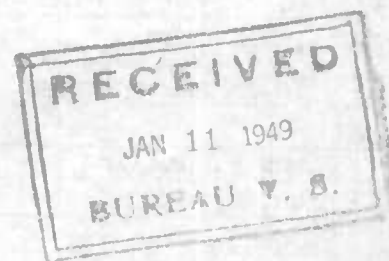
20. DATE OF DEATH... Dec. 31, 1948, at 6:19 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 18, 1945, to Dec. 31, 1948, and that I last saw him alive on Dec. 31, 1948.  
 Immediate cause of death... Pulmonary Tuberculosis  
 DURATION... 11 yrs.  
 Due to...  
 Due to...  
 Other conditions...  
 (Include pregnancy within 3 months of death)

9. Birthplace... Bath, Kentucky  
 (Town, county, and state)  
 10. Usual occupation... Telephone operator  
 11. Industry or business...  
 12. Name... James R. Collins  
 13. Birthplace... Bath, Ky.  
 14. Maiden name... Malassie Breeding  
 15. Birthplace... Bath, Ky.  
 16. Informant... Decedent  
 Address...

Major findings of operations... Date of op...  
 Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

11. ~~removal~~ Date thereof... Jan. 1, 1949  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory...  
 Location...  
 18. Funeral director...  
 Address...  
 19. Jan. 1, 1949 Rowland S. Phillips  
 (Date & by registrar) Registrar

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE... Daniel Leo Pinman MD.  
 M. D. or other  
 Address... Glenn Dale, Md. Date signed... Dec. 31/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *93d*

12710

*245*

### 1. PLACE OF DEATH:

County *Prince Georges*  
City or town *Hydallville Md*  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: *4- Linden ave*  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State *Maryland* County \_\_\_\_\_  
City or town \_\_\_\_\_ Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. *4 D Judson Ave*  
(If rural, give LOCATION) *P.O. Hydallville, Md*  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

*MARY BREEN COLLINS*

### 3. (b) Social Security Number

4. Sex *MALE* 5. Color or race *WHITE* 6. (a) Single, married, widowed, or divorced *MARRIED*

B (b) Name of husband or wife *PATRICK*

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) *Aug 14 - 1889*

8. AGE: Years *59* Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *NEW YORK*  
(Town, county, and state)

10. Usual occupation *House Wife*

11. Industry or business \_\_\_\_\_

12. Name *JOHN BATTLE*

13. Birthplace *NEW YORK*

14. Maiden name *unknown*

15. Birthplace *NEW YORK*

16. Informant *John Breen (Son)*

Address *475-44 St N Y*

17. *Removal* Date thereof *12 31 1948*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location *475-44 St N Y*

18. Funeral director *P. Saffell*

Address *475-44 St N Y*

19. *Dec 31* 19 *48* *James Seery*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 31* 19 *48* at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 18* 19 *48* to *Dec 31* 19 *48* and that I last saw him alive on *Dec 31* 19 *48*

Immediate cause of death *Cardiovascular Heart Failure*  
Due to *hypertensive heart disease*  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)  
Major findings: *none*  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *Robert E. Hance*  
Address *35th Ave N Y* M. D. or other \_\_\_\_\_  
Date signed *3/Dec/48*

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JAN 4 1949

BUREAU V. H.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12711

242

### 1. PLACE OF DEATH:

County Prince George's County  
City or town Seat Pleasant  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Four (4) Months  
Hospital, institution, or street address where death occurred:  
6705 F Street  
How long in hospital or institution? Four (4) Months

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Arlington  
City or town Arlington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 216 N. Wakefield Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

### 3. (a) FULL NAME

**FRANCES C Conner**

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife James B Conner

7. Birth date of deceased (mo., day, yr.) Jan. 29th 1860 6.(c) If alive, give age 88 years

8. AGE: Years 88 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Penna.  
(Town, county, and state) None

10. Usual occupation None

11. Industry or business None

12. Name Charles Robertson

13. Birthplace Unknown

14. Maiden name Ann Nunenaker

15. Birthplace Unknown

16. Informant Mrs Ann R Sherwood

Address 216 No. Wakefield Street, Arl. Va.

17. BURIAL Date thereof Dec. 16, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of interment Cedar Hill Cemetery

Location Suitland, Md. Prince Geo. Co.

18. Funeral director W. W. CHAMBERS COMPANY

Address 1400 Chapin St., N.W., Wash., D.C.

19. Dec. 15 19 48 Carrie Campbell  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1948 at 2:12p

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug-15 19 48 to Dec. 14 19 48

and that I last saw her alive on Dec. 13 19 48

Immediate cause of death Chronic Hypertensive heart disease

Due to Chronic Hypertensive heart disease

Due to Chronic Hypertensive heart disease

Other conditions Chronic Hypertensive heart disease

(Include pregnancy within 8 months of death)

Major findings of operations Chronic Hypertensive heart disease

Date of op. Chronic Hypertensive heart disease

Autopsy results Chronic Hypertensive heart disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Chronic Hypertensive heart disease

Where did injury occur? Chronic Hypertensive heart disease

Injured at home, farm, industry, public place (where?) Chronic Hypertensive heart disease

Means of injury Chronic Hypertensive heart disease

Injured at work? Chronic Hypertensive heart disease

23. SIGNATURE Geo. D. Shepherd M.D.

M. D. or other Chronic Hypertensive heart disease

Address Washington D.C.

Date signed 12.14.48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Prince George

City or town... Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Prince George

City or town... Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4028 Hamilton  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Carl Darnall

## 3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Irene E Darnall

8. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Aug 13, 1887

8. AGE:

Years

Months

Days

If less than one day

61

hrs. min.

9. Birthplace

Wash. DC

(Town, county, and state)

10. Usual occupation

Mech. Engineer

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. Rec'd

(Date rec'd by registrar)

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## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 19 48 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-9

19 48

to 12-30

19 48

and that I last saw him alive on

12-30

19 48

Immediate cause of death

Acute coronary occlusion

DURATION

10 hours

Due to

Coronary Heart Disease

8 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. B. Meyer M.D.

M. D. or other

Address

Int. Medicine Inc.

Date signed

12-31-48

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

REGISTRATION

RECEIVED

JAN 3 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH.

County PRINCE GEORGESCity or town CHEVERLY  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 Yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGESCity or town CHEVERLY  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6127 MONTROSE ROAD.

(If rural, give LOCATION)

WORLD WAR I

2.(a) If veteran name war \_\_\_\_\_

## 3. (a) FULL NAME

DAVID DUNCAN

## 3. (b) Social Security Number

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of ~~husband or~~ wife MAJORIE DUNCAN8. (c) If alive give age 31 years7. Birth date of deceased (mo., day, yr.) OCT. 16<sup>th</sup>, 18928. AGE: Years 56 Months 2 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace SCOTLAND  
(Town, county, and state)10. Usual occupation DRAFTSMAN

## 11. Industry or business

12. Name DAVID DUNCAN13. Birthplace SCOTLAND14. Maiden name EMMA DAWES15. Birthplace SCOTLAND16. Informant MRS. MAJORIE DUNCANAddress 6127 MONTROSE ROAD - CHEVERLY, MD.17. BURIAL Date thereof DEC. 23, 1948  
(month) (day) (year)Cemetery or crematory ARLINGTON NATIONAL CEMETERYLocation ARLINGTON COUNTY, VIRGINIA18. Funeral director W.W. CHAMBERS Co.Address 5801 CLEVELAND AVE. - RIVERDALE, MD.19. 12/21 19 48 Amanda Downey  
(Date rec'd by registrar) Reg. year

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 19 48, at 12<sup>40</sup> P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/30 19 47 to Present 19 48and that I last saw him alive on 12/16 19 48Immediate cause of death Carcinoma, metastaticDue to Carcinoma, colon

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Obtaining carcinoma, spleen, from colon with other metastasesDate of op. 4/25/48

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide \_\_\_\_\_ Date of \_\_\_\_\_

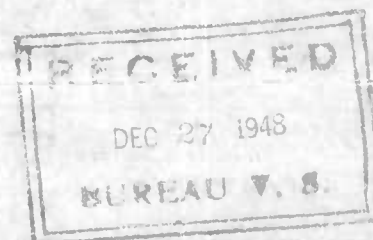
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Julius Kueffner M.D.Address 5102 Annandale Rd. Data signed 12/21/48

M. D. or other





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

### 1. PLACE OF DEATH:

County... Prince Georges  
City or town... Glenn Dale, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 years, 3 mos., 28 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 3 years, 3 mos., 28 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C. County...  
City or town... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... 1431 Potomac Avenue, S. E.  
(If rural, give LOCATION)  
2. (a) If veteran, name war...

### 3. (a) FULL NAME

EOELIN ETHEL H.

### 3. (b) Social Security Number

577-10-2120

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William R. Edelin

6. (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) May 2, 1915

8. AGE: Year 33 Month 33 Day 23 (If less than one day... hr. min.)

9. Birthplace Charleston, South Carolina (Town, county, and state)

10. Usual occupation Typist

11. Industry or business - - -

FATHER 12. Name William A. Hamilton

13. Birthplace ? Ohio

MOTHER 14. Maiden name Anna Wignor

15. Birthplace ? Illinois

16. Informant Deceased

Address

17. Burial Date thereof 12/28/48 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cemetery

Location Washington, D. C.

18. Funeral director I am Lee Sons Co.

Address 300 - 4th St N.E.

19. Dec. 25, 1948 Rowland S. Phillips (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1948 at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/27 1945 to 12/25 1948 and that I last saw him alive on 12/25 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 40 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Daniel Lee Pinicare MD.

M. D. or other

Address Glenn Dale, Md.

Date signed 12/25/48

MARGIN RESERVED FOR BINDING

I

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 5 1949

BUREAU T. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Crofton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 36 days  
 Hospital, institution, or street address where death occurred: Prince Georges Hosp. tal  
 How long in hospital or institution? 36 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Prince Georges  
 City or town Beltsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Gates Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Mrs. Virginia Edwards

## 3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Irving Edwards  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) January 13, 1914  
 8. AGE: Years 34 Months 9 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

MOTHER FATHER  
 12. Name John Howard Flora  
 13. Birthplace Highland Md  
 14. Maiden name Agnes Eldredson  
 15. Birthplace Silver Spring, Md  
 16. Informant Irving H. Edwards - Husband  
 Address Gates Rd. Beltsville Md  
 17. Burial Date thereof 12/1/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Union Cemetery  
 Location Beltsville, Md  
 18. Funeral director Arthur J. [unclear]  
 Address 566 Park Blvd. Laurel, Md.  
 19. 12/2 48 Ananda Dourney  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 December 1948 at 5:35 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN 48 to DEC 48  
 and that I last saw him alive on 30 NOV 48  
 Immediate cause of death Cervix with extension to bladder  
 Due to Benign prostatic hyperplasia  
 Due to Broncho pneumonia  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings at operations as above  
 Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE W. E. [unclear] M. D. or other  
Berwyn, Md Address \_\_\_\_\_ Date signed 12-2-48

RECEIVED

DEC 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 234

12716

164c

## 1. PLACE OF DEATH:

County Prince George'sCity or town Camp Springs  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

5405 Middleton Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Camp Springs  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5405 Middleton Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles P. Farr

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Theodora Farr

## 7. Birth date of

deceased (mo., day, yr.)

April 27, 1910

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

38

hrs. min.

## 9. Birthplace

Pittsburg, Pa.  
(Town, county, and state)

## 10. Usual occupation

Policeman

## 11. Industry or business

D.C. Police

## FATHER

## 12. Name

Charles Farr

## 13. Birthplace

England

## MOTHER

## 14. Maiden name

Elizabeth Gugel

## 15. Birthplace

Braddock, Pa.

## 16. Informant

Theodora Farr

## Address

5405 Middleton Lane S.E., D.C.

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

Dec 11 - 48  
(month) (day) (year)

## Cemetery or crematory

St. Barnabas Cemetery

## Location

near Hill Md.

## 18. Funeral director

Arthur E. Simmons Jr.

## Address

2007 Nichols Dr S.E.

## 19.

(Date rec'd by registrar)

Dec 101948James J. Hall

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19   to 19  and that I last saw h. alive on 19  

Immediate cause of death

Hemorrhage and shock

## DURATION

Due to Gun shot wound of the head

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 12/8/48Where did injury occur? Camp Springs P. G. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Shot selfInjured at work? No

Deputy Medical Examiner

23. SIGNATURE

James J. HallM. D. Author

Address

Forestville, Md.Date signed 12/9/48

RECEIVED

DEC 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 289

## 1. PLACE OF DEATH:

County Prince George  
 City or town Lanell MD-1  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George  
 City or town Lanell  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 608 Montgomery St  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

Sarah Elizabeth Fink  
 4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife John Fink7. Birth date of deceased (mo., day, yr.) June 3, 18788. AGE: Years 70 Months 6 Days 15 If less than one day

9. Birthplace Montgomery Co. Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business None

12. Name John S. Hammond13. Birthplace Montgomery Co. Maryland14. Maiden name Molly Blyden15. Birthplace Montgomery Co. Maryland16. Informant Ruth Hammond WhiteheadAddress 610 Montgomery St., Lanell, Md17. Burial Date thereof Dec 21, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory My Will CemeteryLocation Lanell, Maryland18. Funeral director Dr. With SmallmanAddress Lanell, Maryland19. Dec 20 19 48 M. Brashears  
 (Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH December 18 19 48 at 7:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/16/47 19 47 to 12/18/48 19 48and that I last saw him alive on 12/18/48 19 48Immediate cause of death Pulmonary TuberculosisDURATION 7 -

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

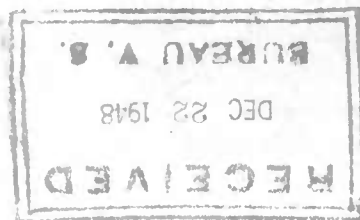
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Brashears M. D. or otherAddress Lanell, Md Date signed 12/21/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12718  
245

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Hyattsville, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

4102 - Madison Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4102 - Madison Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Grace Madison Fisher

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Joseph A. Fisher

7. Birth date of deceased (mo., day, yr.)

July 7, 1879

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

69524

hrs.

min.

9. Birthplace

Fullton County, Penn  
(Town, county, and state)

10. Usual occupation

House - wife

11. Industry or business

MOTHER FATHER

12. Name

William H. Reed

13. Birthplace

Franklin County Pa

14. Maiden name

Martina Knable

15. Birthplace

Penn

16. Informant

Howard Fisher

Address

Savage, Md.

17.

Burial  
(Burial, cremation, or removal, which?)

Date thereof

Jan 2 / 49  
(month) (day) (year)

Cemetery or crematory

National Capital Mem Park

Location

Murphy's Road

18. Funeral director

W. E. Smith & Sons

Address

Laurel, Md.

19.

Dec 31, 44  
(Date rec'd by registrar)

19

James Severy

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 31 1944 at 2-45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

19

19

and that I last saw him alive on

Immediate cause of death

Hypertensive heart disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John D. Maloney Deputy  
Chivery - Hyattsville, Md. M. D. or other  
Date signed 1-2-31-45

RECEIVED

JAN 3 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince George CountyCity or town Mt. Rainier Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

3209 Perry St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia CountyCity or town Arlington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2300 N. Columbus St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charlotte E Fowler

## 3. (b) Social Security Number

## 4. Sex

7

## 5. Color or race

W.

## 6.(a) Single, married, widowed, or divorced

8 -

## 6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1 - 48

## 8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

9. Birthplace Arlington Hosp Va.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name Charles E. Fowler Jr.13. Birthplace Baltimore Md.14. Maiden name Phyllis Ann Cunningham15. Birthplace Washington D. C.16. Informant Mrs Della Nursing HomeAddress 3209 Perry St. Mt. Rainier Md.17. Burial Date thereof Dec. 1 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory National Memorial ParkLocation Fairfax Co. Va.18. Funeral director C. H. IvesAddress 2847 Wilson Blvd. Arlington, Va.19. Dec 1 Dr James Severy  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Hydrocephalus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John D. Maloney Deputy  
Cherly. Hyattsville Md. Medical Exam  
M. D. or otherAddress Cherly. Hyattsville Md. Date signed 12-1-48

RECEIVED

DEC 4 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 239

### 1. PLACE OF DEATH:

County Prince George  
City or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:

Warren Hospital  
How long in hospital or institution? 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harward

City or town Savage  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Baltimore Ave  
(If rural, give LOCATION)

2(a) If veteran, name war ✓

### 3. (a) FULL NAME

Katie Florence Frazer

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife James J. Frazer

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1876

8. AGE: Years 72 Months - Days 2 If less than one day hrs. min.

9. Birthplace Shenandoah Co. Mt. Jackson, Va.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name Charles Stoneburner

13. Birthplace Virginia

14. Maiden name Melinda Brinkman

15. Birthplace Mt. Jackson, Virginia

16. Informant Rev. Mrs. Minnie Perkins

Address Savage, Maryland

17. Burial, cremation, or removal, Which? Burial Date thereof Dec 18, 1945  
(month) (day) (year)

Cemetery or crematory Savage Cemetery

Location Savage, Maryland

18. Funeral director Dr. W. H. Caldwell

Address Laurel, Maryland

19. Dec 17 19 45 M. Brashear  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 19 45 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 19 45 to Dec 14 19 45

and that I last saw her alive on Dec 13 19 45

Immediate cause of death Pneumonia lobar

### DURATION

2 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William R. Brunge, M.D.

M. D. or other

Address Laurel Date signed 12/17/45

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *265*

## 1. PLACE OF DEATH:

County *Prince George*City or town *Riversdale, Md.*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*Deland Memorial Hospital*

How long in hospital or institution?

*3 1/2 days*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Prince George*City or town *Mt. Rainier*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *4224 - 29th St.*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*Funk, Gaucher Lee*

## 3. (b) Social Security Number

-

4. Sex

*male*

5. Color or race

*white*

6.(a) Single, married, widowed, or divorced

*married*6.(b) Name of husband or wife *Blanche Olivia**Funk*6.(c) If alive, give age *62* years

7. Birth date of deceased (mo., day, yr.)

*June 18, 1882*

8. AGE:

Years

Months

Days

If less than one day

*66**5**27*

hrs.

min.

9. Birthplace

*Fred. County, Md.*  
(Town, county, and state)

10. Usual occupation

*Paper hanger*

11. Industry or business

*self*

MOTHER FATHER

12. Name

*Silas Clinton Funk*

13. Birthplace

*Fred. County, Md.*

14. Maiden name

*Martha Ellen Clifton*

15. Birthplace

*Fred. County, Md.*

16. Informant

*Hospital Record*

Address

*4408 Quernbury Rd. Riversdale*

17.

*Burial*  
(Burial, cremation, or removal. Which?)

Date thereof

*Dec. 17, 1948*  
(month) (day) (year)

Cemetery or crematory

*Washington Memorial Park*

Location

*Riggs Rd. Md. Prince Geo. Co.*

18. Funeral director

*William J. Nalley*

Address

*3200 - R.I. Ave. Mt. Rainier, Md.*

19.

*Dec 16 48*  
(Date rec'd by registrar)*James Sevey*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *December 15* 19 *48*, at *5:51* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death *Hemorrhage & shock*

DURATION

Due to *Fracture of femur & pelvis*Due to *Impact by automobile*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *Dec 11, 1948*Where did injury occur? *Brentwood Br. Geo. Md.*  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) *Public highway*Means of injury *Ballistic impact into side of automobile* Injured at work? *no*

23. SIGNATURE

*John W. Maloney, Dep. Med. Exam*  
*Riversdale, Md. M. D. of other*Address *4408 Quernbury Rd.* Date signed *12/15/48*

RECEIVED

DEC 18 1948

BUREAU 7. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12722 242

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Dulles Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr  
 Hospital, institution, or street address where death occurred:  
none  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George's  
 City or town Washington 19 DC  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1905 - Hambleton Drive  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war none

## 3. (a) FULL NAME

Carl Harold Gilbert

## 3. (b) Social Security Number

214-03-6582

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white widowed

8. (b) Name of husband or wife Bessie May Gilbert

7. Birth date of deceased (mo., day, yr.) July 4 1880 6. (c) If alive, give age — years

8. AGE: Years 68 Months 4 Days 28 If less than one day  
— hrs. — min.

9. Birthplace Xenton, Ohio  
 (Town, county, and state)

10. Usual occupation Retired Grocer

11. Industry or business unemployed

12. Name James Brad Gilbert

13. Birthplace Virginia

14. Maiden name Belle Grady

15. Birthplace unknown

16. Informant Mrs. Eliza Lamberson

Address Upper Marlboro, Md.

17. Burial Date thereof Dec. 4, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cheltenham M.E. Church Am.

Location Cheltenham, Maryland

18. Funeral director Ritchie Bros.

Address Upper Marlboro, Md.

19. Dec. 3 19 48 Edna F. Collins  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 19 48 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24, 1948 to Dec 2 19 48

and that I last saw him alive on Dec 1 19 48

Immediate cause of death acute congestive heart failure

Due to Bronchopneumonia

Due to —

Other conditions Chronic Bronchitis

General Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations —

Antopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide unkind

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of Injury — Injured at work? —

23. SIGNATURE William H. Hatcher

Address Washington 19 DC

Date signed Dec 24 19 48

RECEIVED

DEC 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Oxen Hill  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? transit  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Oaklawn Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 7392 Allentown Road  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Samuel Oswald Gouldman

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Monnee Gouldman  
6. (c) If alive, give age 46 years  
7. Birth date of deceased (mo., day, yr.) Nov 25, 1891  
8. AGE: Years 57 Months Days If less than one day  
hrs. min.

9. Birthplace Virginia King Georges County  
(Town, county, and state)10. Usual occupation taxicab driver

## 11. Industry or business

FATHER 12. Name John Oswald Goldman  
13. Birthplace Virginia  
MOTHER 14. Maiden name Ann Willis White  
15. Birthplace Virginia

16. Informant Mrs Grace Mills  
512 Tennessee ave Alexandria va.  
Address

17. Burial Date thereof Dec 16, 1948  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Ox Hill  
Location Suitland, Md.

18. Funeral director F. Guacha song  
Address Hyattsville Md.

19. Dec 19 1948 Amenda H Brown Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1948 at 1000 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19..... to 19.....  
and that I last saw him..... alive on 19.....

Immediate cause of death  
Fracture of base of skull  
Crushed chest  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide assault Date of 12-12-48  
Where did injury occur? Ox Hill (City or town) Prince Georges (County) Md (State)  
Injured at home, farm, industry, public place (where?) Ox Hill  
Means of injury gun Injured at work? no  
legally illegal  
23. SIGNATURE Amenda H Brown M. D. or other  
Address Hyattsville Md Date signed 12-13-48

RECEIVED

DEC 20 1948

BUREAU 7. 3.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

13724

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Beaver Heights Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Prince Georges  
 City or town Beaver Heights Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4700 - R. street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Edgar Alberton Hargleroad

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

unmarried

## 6. (b) Name of husband or wife

Clara Hargleroad

## 7. Birth date of

deceased (mo., day, yr.)

Sept 12, 1867

## 8. AGE:

Year

Months

Days

If less than one day

81

hrs.

min.

## 9. Birthplace

Penna  
Retired  
(Town, county, and state)

## 10. Usual occupation

Penna Railroad Co

## 11. Industry or business

unknown

## MOTHER

## FATHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

## (Burial, cremation, or removal. Which?)

## Date thereof

## (month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. Date rec'd by registrar

## 1948

## Registrar

## Address

## Date signed

## 7 Dec 48

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec 7, 1948, at 1:30 P. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 Dec 48 to 7 Dec 48and that I last saw him alive on 7 Dec 48Immediate cause of death acute cardiac failure

## DURATION

24h.

## Due to

Chronic coronary heart disease

## Due to

atherosclerosis

## Other conditions

(Include pregnancy within 5 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

Date signed

329 - E. Kent St. 7 Dec 48



RECEIVED  
DEC 10 1948  
BUREAU 7. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12726 745

### 1. PLACE OF DEATH:

County Prince Georges, Md.  
City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yrs 6 mos.  
Hospital, institution, or street address where death occurred:  
5805 Queen Chapel Rd. Sacerd Heart Home  
How long in hospital or institution? 4 yrs 6 mos. (last 50)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Washington County District of Columbia  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2201 Wyoming Ave. N.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

ANNIE HARRIET HARRISON

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife George Harrison

7. Birth date of deceased (mo., day, yr.) APRIL 23, 1896 6.(c) It alive, give age 48 years

8. AGE: Years 72 Months 8 Days 2 If less than one day hrs. min.

9. Birthplace ENGLAND  
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

12. Name GEORGE HARRISON

13. Birthplace ENGLAND

14. Maiden name JANE HIGHWAY

15. Birthplace ENGLAND

16. Informant Sacerd Heart Home  
Address 5805 Queen Chapel Rd, Hyattsville, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof Dec. 28, 1948  
(month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington, D.C.

18. Funeral director Francis Oberlin

Address 3821-14th St. N.W., Wash. D.C.

19. Dec 26 1948 James Seery  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 26 1948 at 11:30 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to December 2 1948 and that I last saw him alive on Dec 25 1948

Immediate cause of death Congestive heart failure DURATION one month

Due to arteriosclerotic heart disease 2 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

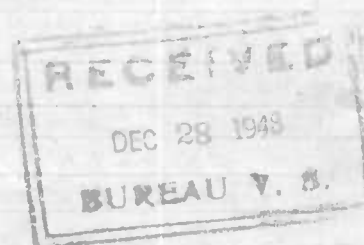
23. SIGNATURE James Seery M. D. or other

Address 322-H St NE Date signed 12-26-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *245*

## 1. PLACE OF DEATH:

County *Prince Georges*City or town *Riverdale Md*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *7 years 5 months*Hospital, institution, or street address where death occurred: *-*How long in hospital or institution? *-*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Prince Georges*City or town *Riverdale Md*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *4705 River street*

(If rural, give LOCATION)

2. (a) If veteran, name war *-*

## 3. (a) FULL NAME

*Frederick John Hartman*

## 3. (b) Social Security Number

4. Sex *male*5. Color or race *white*6. (a) Single, married, widowed, or divorced *married*6. (b) Name of husband or wife *Mary J. Hartman*6. (c) If alive, give age *-* years7. Birth date of deceased (mo., day, yr.) *Feb 25, 1876*8. AGE: Years *72* Months *-* Days *-* If less than one day *-* hrs. *-* min. *-*9. Birthplace *Rock Island - Illinois*

(Town, County, and state)

10. Usual occupation *Draftsman*11. Industry or business *self*12. Name *Charles Hartman*13. Birthplace *Germany*14. Maiden name *Emma Hopfberg*15. Birthplace *Washington D.C.*16. Informant *Mrs Mary J. Hartman*Address *Riverdale Md*17. Burial *Burial* Date thereof *Dec 14, 1948*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Greenwood Cemetery*Location *Washington D.C.*18. Funeral director *F. Casche song*Address *Hyattsville Md*19. *Dec 13* *14* James Severy

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 11, 1948* at *1:15 P.*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *3-7-48* to *12-11-48*and that I last saw him *12-11-48* alive on *12-11-48*Immediate cause of death *Cerebral hemorrhage*DURATION *8 hrs*Due to *Hypertension* *18 yrs*Due to *-*Other conditions *-*

(Include pregnancy within 8 months of death)

Major findings of operations *-*Date of op. *-*Autopsy results *-*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *-* Date of *-*

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury *-* Injured at work? *-*23. SIGNATURE *John P. Clum M.D.*Address *Hyattsville Md* Date signed *12-13-48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 14 1948

BUREAU V. S.

FILM No. G 118 JAN 21 1949

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County... Prince Georges

City or town... Cheverly

(If outside city or town limits, write RURAL and give near-at town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Slate... D.C.

County

City or town... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4031--19th Street, N.E.

(If rural, give LOCATION)

none

2.(a) If veteran, name war

3. (a) FULL NAME

LOUISE HAUSEN

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

March 26th, 1860

8. AGE:

Years

Months

Days

If less than one day

88

hrs.

min.

9. Birthplace

Hamburg, Germany

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Germany

MOTHER

14. Maiden name

Sophia VonHolt

15. Birthplace

Germany

16. Informant

Mrs. Charles E. Summers

Address

4031-19th St. N.E. Wash. D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 22nd, 1948

(month) (day) (year)

Cemetery or crematory

Montrose Cemebery

Location

Chicago, Ill.

18. Funeral director

W.W. Chambers Company

Address

5801 Cleveland Ave., Riverdale, Md.

19.

Dec 20 48

19.

48

Amanda P. Rooney

Registrar

23. SIGNATURE

1833-Monroe St. signed 12-20-48

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 20th

1948

at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-13

19

45

to

11-20

19

48

and that I last saw him alive on 12-19-48.

Immediate cause of death

Respiratory

failure with acute heart failure

DURATION

3 days

Due to

Senility

Due to

Other conditions

Fracture Hip

11 days

(Include pregnancy within 3 months of death)

Major findings of operations

Open reduction of fracture in neck of 2nd hip

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Dec 6, 1948

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Home

Means of injury

Slipped & fell in back of work

19.

Dec 20 48

19.

48

Amanda P. Rooney

Registrar

23. SIGNATURE

1833-Monroe St. signed 12-20-48

M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
DEC 21 1948  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243.

1. PLACE OF DEATH: Prince Georges  
 County.....  
 Glenn Dale, Maryland  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr., 3 mos., 27 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 1 yr., 3 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... D. C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1720 Florida Avenue, N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3.(a) FULL NAME  
 HAWKINS, BROADUS

3.(b) Social Security Number  
 - - -

4. Sex Female  
 5. Color or race Negro  
 6.(a) Single, married, widowed, or divorced Separated  
 6.(b) Name of husband or wife Joseph Hawkins  
 6.(c) If alive, give age Late 50's years  
 7. Birth date of deceased (mo., day, yr.) January 7, 1890  
 8. AGE: Years 58 Months 58 Days 10 It less than one day 26 hrs. min.

9. Birthplace Colonial Beach, Virginia  
 (Town, county, and state)  
 Seamstress  
 10. Usual occupation  
 11. Industry or business  
 12. Name George Jackson  
 13. Birthplace ?  
 14. Maiden name S. Watson  
 15. Birthplace W. Moreland Co., Virginia

16. Informant Deceased  
 Address  
 17. Removal to work, D.C. Date thereof Dec 3 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory  
 Location  
 18. Funeral Director Daniel H. Edmonson  
 Address 2000-9th St. N.W.  
 19. Dec 3, 1948 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1948 at 12:10 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5th 1947 to Dec 3rd 1948 and that I last saw her alive on Dec 2nd 1948  
 Immediate cause of death Pulmonary Tuberculosis DURATION 2 yrs 5 mos  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 8 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Daniel Leo Pincus M.D.  
 Address Glenn Dale Md Date signed 12/3/48

RECEIVED

DEC 13 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **230**

### 1. PLACE OF DEATH:

County Prince Georges  
City or town Lake land  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 124m  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Prince Georges  
City or town Lake land, Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Virginia Hill

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Aug 26, 1936

8. AGE: Years 12 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Lake land, Md  
(Town, county, and state)

10. Usual occupation Child

11. Industry or business \_\_\_\_\_

FATHER 12. Name Olusami Hill 13. Birthplace Lake land, Md

MOTHER 14. Maiden name Fanny Lancaster 15. Birthplace Montgomery County, Md

18. Informant Abraham Hill (father)  
Address Lake land, Md

17. Burial Date thereof Dec 21 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Very or crematory Harmony  
Location Washington D C

18. Funeral director F. Gaskins sons  
Address Hyattsville Md

19. 12/26 1948 Amanda Doney  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1948 at 7 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Asphyxia

Due to Cerebral palsy (Spastic)

Due to diplegia

Due to Aspiration of vomitus

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE T. A. Christensen M. D. or other \_\_\_\_\_

Address College Park, Md Date signed 12/29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12729

195d



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Greenbelt  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Greenbelt  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 105 Ridge Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Joan Katz7. Birth date of deceased (mo., day, yr.) Dec 18, 1920

8. AGE: Years 28 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
(Town, county, and state)10. Usual occupation Bookman11. Industry or business Washington Terminal12. Name Norman Katz13. Birthplace Chattanooga, Tenn14. Maiden name Phyllis Norman15. Birthplace Prince Georges, Md16. Informant FatherAddress Washington St.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec 30, 1948  
(month) (day) (year)Cemetery or crematory Cedar HillLocation Smithland Md18. Funeral director F. Pasche SonsAddress Hyattsville Md19. Dec 30 19 48 Amanda Downey Registrar

(Date rec'd by registrar)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 19 48 at 5:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Gunshot wound of head from within the st. Vincent area

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 12/28/48Where did injury occur? Greenbelt Prince Georges Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Gunshot Injured at work?23. SIGNATURE Thomas A. Christman, M.D.Address College Park Md Date signed 12/28/48

RECEIVED

JAN 3 1949

BUREAU U. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *245*

12731

### 1. PLACE OF DEATH:

County *Prince George's*

City or town *Hyattsville Md.*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *35 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Prince George's*

City or town *Hyattsville Maryland*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. *5505 42th avenue*  
(If rural, give LOCATION)

2.(a) if veteran, name war

### 3. (a) FULL NAME

*Henry Peyton Howard*

### 3. (b) Social Security Number

4. Sex

*Male*

5. Color or race

*white*

6.(a) Single, married, widowed, or divorced

*married*

6.(b) Name of husband or wife *Henrietta Dyer Howard*

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Jan 22, 1877*

8. AGE:

*71-*

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace *Washington D. C.*  
(Town, county, and state)

10. Usual occupation *Notary Public*

11. Industry or business

FATHER

12. Name

*Henry P. Howard*

13. Birthplace

*Washington D. C.*

14. Maiden name

*Roberta Dyer*

15. Birthplace

*Washington D. C.*

16. Informant *Henry Peyton Howard*

Address *Washington 16, D. C.*

17. *Burial* Date thereof *Dec 3, 1948*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. *Dec 2*  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 1 1948* at *8:40* A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Nov 30 1948* to *Dec 1 1948*

and that I last saw him alive on *Dec 1 1948*

Immediate cause of death

*Coronary thrombosis*

DURATION

*1 day*

Due to *arteriosclerosis*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address *Hyattsville Md.* Date signed *Dec 1/48*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

DEC 6 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 242

12732

83a

1. PLACE OF DEATH:  
County... Prince George's  
City or town... Jefferson Heights  
(If outside city or town limits, write RURAL and give nearest town)  
How long above place of death? 10 days  
Hospital, institution, or street address where death occurred:  
6600 - H St. N.E.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... Maryland County... Prince Georges  
City or town... Jefferson Heights  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6600 - H St. N.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME  
Andy A. Jackson

3.(b) Social Security Number

4. Sex male 5. Color or race black 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife... Ella Jackson  
6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1890

8. AGE: Years 58 Months 2 Days 16 If less than one day  
hrs. min.

9. Birthplace Rockville, Md.  
(Town, county, and state)

10. Usual occupation... Cook, R.R.

11. Industry or business... Rail Road

12. Name... Andy Jackson

13. Birthplace... Montgomery County, Md.

14. Maiden name... unknown

15. Birthplace... unknown

16. Informant... Ella Jackson

Address 6600 - H St. N.E.

17. Burial Date thereof 1-1-1949

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Payne

Location... Sumner Rd. N.E. Wash. D.C.

18. Funeral director... Henry S. Washington & Sons

Address 467 N St. N.W. Wash. D.C.

Dec 30 1948 Carrington Campbell

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29, 1948, at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1948, to Dec 29, 1948

and that I last saw him alive on Dec 29, 1948

Immediate cause of death... Cerebral Hemorrhage

DURATION

Due to... Hypertension

Due to... 7

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. B. Beldon M.D.

Address 4423 - H St. N.E. Wash. D.C.

Date signed Dec 29, 1948

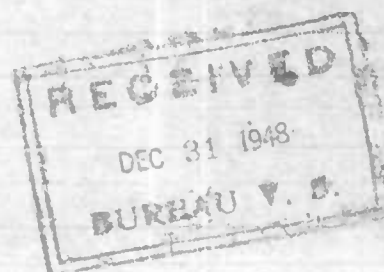
MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
birth date shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 110 JAN 11 1949

## CERTIFICATE OF DEATH

Reg. Dist. No. 12733  
2334  
HBS

### 1. PLACE OF DEATH:

County Prince Geo  
City or town No. Pimattaway Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Prince Geo  
City or town No. Pimattaway Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Frederick Jackson

### 3. (b) Social Security Number

4. Sex M 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) XXXXXX 1854

8. AGE: Years 94 Months Days If less than one day hrs. min.

9. Birthplace Prince Geo Co  
(Town, county, and state)  
Farmer

10. Usual occupation

11. Industry or business

12. Name Andrew Jackson  
13. Birthplace Prince Geo Md

14. Maiden name Mary  
15. Birthplace Prince Geo Md

16. Informant Russell Jackson  
Address Over Hill Md

17. Burial Date thereof 12-27-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Mary  
Location Pimattaway Md

18. Funeral director Harold Johnson  
Address Waldorf Md

19. 12/27 18 M. McCouard  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1948 at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8 1948 to Dec 23 1948 and that I last saw him alive on Dec 23 1948

Immediate cause of death Cardiac Failure  
Due to Chronic Cardiac Degeneration

Other conditions Chronic Arteriosclerosis  
Arteriosclerosis  
(Include any disease within 3 months of death)

Major findings of operation None  
Date of op.

Autopsy results None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Edwin B. Long M.D.  
Address Waldorf Md Date signed 12/28/48

RECEIVED

JAN 4 1949

BUREAU V. S.



RECEIVED

DEC 31 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12735  
514

## 1. PLACE OF DEATH:

County Prince Georges  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 mo. 17 days  
Hospital, institution, or street address where death occurred:  
6407 Eastern Avenue  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County Bronx  
City or town New York City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4054 Hill Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war

## 3. (a) FULL NAME

Mary Madeline Kaste

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife George Daniel Kaste  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) March 23 1872  
8. AGE: Years 76 Months 8 Days 12 If less than one day hrs. min.

9. Birthplace New York City, N.Y.  
(Town, county, and state)  
10. Usual occupation House wife  
11. Industry or business Home  
12. Name Joseph Weber  
13. Birthplace Germany  
14. Maiden name Eva Breitenbach  
15. Birthplace Germany

16. Informant Mrs. Julia J. Blend  
Address 6407 Eastern Ave. Takoma Pk. Md.  
17. Removal Date thereof Dec 5-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory — (new city)  
Location Washington D.C.  
18. Funeral director W. W. Chasman Co.  
Address 1400 - Chapin St. Mt.  
19. Dec 5 19 48 Joseph Weber  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1948 at 11<sup>25</sup> P. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1948 to Dec 4, 1948 and that I last saw her alive on December 4, 1948  
Immediate cause of death Gangrene of left foot DURATION 11 mo.  
Due to Generalized arterio-sclerosis, advanced years  
Due to  
Other conditions Terminal gastro-intestinal hemorrhage Hours  
(Include pregnancy within 3 months of death)  
Major findings of operations Dry gangrene of 2nd toe, left foot Date of op. 5-30-48  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Wallace H. Mool M.D. M. D. or other  
Address Takoma Park Md. Date signed 12-5-48

RECEIVED

DEC 7 1948

BUREAU V. S.

Evidence for change of  
age and birth date shown on:

FILE NO. G 118 JAN 11 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George

City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 minutes

Hospital, institution, or street address where death occurred:

Prince George Genl

How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5013 Edmonston Rd  
(If rural, give LOCATION)

2(a) If veteran, name war Hyattsville, Md.

3. (a) FULL NAME

Beltram  
James Kearns

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (d) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife Lou Beatha Kearns

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.) June 2, 1888

8. AGE: Years Months Days If less than one day

64 5 23 hrs. min.

9. Birthplace VIRGINIA

(Town, county, and state)

10. Usual occupation ENGINEER

11. Industry or business

12. Name James Philip Kearns

13. Birthplace

14. Maiden name Unknown

15. Birthplace Va

16. Informant Mrs Lou B Kearns

Address Hyattsville Md

Burial Date thereof Dec 29, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Lincoln

Location Colmar Manor Md

18. Funeral director F Gaechi sons

Address Hyattsville Md

19. 12/29 19 48 Ananda Dorney

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25, 1948 19 48 at 4:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 19 48 to Dec 25 19 48

and that I last saw him Dec 25 19 48

Immediate cause of death Myocardial

Infarction DURATION 1 hr.

Due to Coronary Occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ralph L. McLaughlin, MD

Address 3717 38th Ave Date signed 12-25-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12737

239

## 1. PLACE OF DEATH:

County PRINCE GEORGE  
 City or town LAUREL, MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? SINCE JULY 8, 1945  
 Hospital, institution, or street address where death occurred:  
LAUREL SANITARIUM  
 How long in hospital or institution? SINCE JULY 8, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town WASHINGTON  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4400 ORD ST NE  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

SIDNEY HARRY KENT

## 3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWER  
 6.(b) Name of husband or wife SARAH KRATER KENT  
DIED 1934 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) JULY 14, 1867  
 8. AGE: Years 81 Months 5 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace BALTIMORE, MARYLAND  
 (Town, county, and state)  
 10. Usual occupation CHIEF CLERK, ADJ GEN.  
 11. Industry or business OFFICE - WAR DEPT  
 12. Name BENJAMIN GEORGE KENT  
 13. Birthplace ENGLAND.  
 14. Maiden name SUSAN M  
 15. Birthplace ENGLAND.

16. Informant SON - HARRY K. KENT  
 Address 4400 ORD ST. NE - WASH - DC

17. Buried Date thereof 12-27-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill  
 Location Prince George Co.  
 18. Funeral director Cherry Chase Funeral Home  
 Address 5103 W. Ave N.W.  
Dec 24 48 Registrar M. Brashear  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

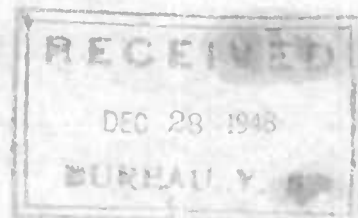
20. DATE OF DEATH DECEMBER 24 1948 at 3:35 A.M.  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 8 1945 to Dec. 24 1948  
 and that I last saw him alive on Dec. 23 1948  
 Immediate cause of death Cardiac failure

Due to Senility Cardio-vascular disease; arteriosclerosis  
 Due to Senility  
 DURATION 5 yrs.

Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. F. Robinson M. D. or other \_\_\_\_\_  
 Address Laurel Sanitarium Laurel Md Date signed Dec 24 1948





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 159

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Chesley  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 hr 47 min

Hospital, institution, or street address where death occurred:

Prince George GeneralHow long in hospital or institution? 1 hr 47 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince GeorgeCity or town Hyattsville, MD  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3914 Longfellow ST  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Joan Baby Girl Kieckhefer

## 3. (b) Social Security Number

4. Sex

f white single

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife mother Mrs Claire Kieckhefer7. Birth date of deceased (mo., day, yr.) 12-25-488. AGE: Years Months Days If less than one day  
1 hrs. 47 min.9. Birthplace Prince George  
(Town, county, and state)10. Usual occupation Baby

11. Industry or business

12. Name Robert Louis Kieckhefer13. Birthplace Ill. No.14. Maiden name CLARE B. LA Pointe15. Birthplace Maine16. Informant Chart

Address

17. Cremation Date thereof Jan. 1, 1949  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prince George General HospitalLocation Chesley, MD18. Funeral director G.R. Brady, Supt.Address Chesley, MD19. 1/4 49 Amanda Durney  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-48 1948 at 1:02 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
birth to death 1948 to 1948and that I last saw h. ex alive on 12-26-48 1948Immediate cause of death Prematurely

DURATION

Due to PrematurelyDue to Prematurely

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

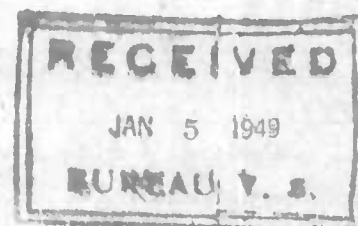
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Julius Foyd M.D. M.D. or otherAddress 5212 Balt. Ave Date signed 12-28-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age shown on:

FILM No. G 118 DEC 13 1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

12739

### 1. PLACE OF DEATH:

County Prince George's  
City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

CHARLES BROOKS

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Carrie Belle (deceased)

7. Birth date of deceased (mo., day, yr.) March 17, 1877 6. (c) If alive, give age ..... years

8. AGE: Years 71 Months 69 Days ..... If less than one day ..... hrs. .... min.

9. Birthplace Morgantown, West Virginia.  
(Town, county, and state)

10. Usual occupation Elevator operator

11. Industry or business Columbia Med. Bldg. Wash. DC

FATHER 12. Name John K. Kissner

13. Birthplace West Virginia

MOTHER 14. Maiden name Mary Melvina Lawson

15. Birthplace West Virginia

16. Informant Mrs. Mary A. Mohun

Address 5014 37th. Pl. Hyattsville, Md.

17. BURIAL Date thereof DEC 6 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MT. OLIVET CEMETERY

Location WASHINGTON, DC

18. Funeral director W. W. Chamber G

Address 5801 CLEVELAND AVE - RIVERDALE, MD

19. DEC 3 19 48 James Seely  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5014 37th. Pl.  
(If rural, give LOCATION)

2. (a) If veteran, name war .....

### 3. (b) Social Security Number

214-07-1030

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 19 48 at 2:45 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 19 48 to 12-2 19 48 and that I last saw him alive on 12-2 19 48

Immediate cause of death Coronary infarction

Due to hypertensive cardiovascular disease

Due to Diabetes

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State) .....

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE George Magrath

M. D. or other .....

Address 3711-3806 Ave Date signed 12/2/48

4471

RECEIVED

DEC 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12740

245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Riverdale Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges  
 City or town Riverdale Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5902 Ravenswood Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

CLAUDE C. KITCHIN

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Anna M. Orton  
 7. Birth date of deceased (mo., day, yr.) Sept. 30 - 1883 8.(c) If alive, give age 63 years  
 8. AGE: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
 (City, town, county, and state)

10. Usual occupation Pressman

## 11. Industry or business

12. Name Charles Wm. Ritchie  
 13. Birthplace Virginia  
 14. Maiden name Harriet Ann Mahoney  
 15. Birthplace Va.

16. Informant Anna L. Austin

Address 6009 Somerset Rd. Riverdale Md.

17. Burial Date thereof Jan 4 1949  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Belmar Manor, P. Geo. Co. Md.

18. Funeral director Wm. J. Nalley

Address 3200-R.R. Ave. Mt. Rainier Md.

19. Jan 4 19 49 Amanda H. Lowe  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 19 48 at 7:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 48 to Dec 31 19 48  
 and that I last saw him alive on Dec 31 19 48

Immediate cause of death Cerebral thrombosis DURATION 2 weeks

Due to Cerebral thrombosis 5 years

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE L. J. Austin M. D. or other

Address 1427 N. Cap St. Date signed \_\_\_\_\_

RECEIVED

JAN 7 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George  
 City or town Cheverly  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days 5 hours  
 Hospital, institution, or street address where death occurred:  
PRINCE GEORGE GENERAL  
 How long in hospital or institution? 2 days 5 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George  
 City or town Cottage City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4004 Bladensburg Rd.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war World War I

## 3. (a) FULL NAME

Thomas D. Kleh  
 4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced MARRIED  
 6.(b) Name of husband or wife Nora A. KLEH  
 7. Birth date of deceased (mo., day, yr.) May 11, 1892  
 6.(c) If alive, give age Deceased years

## 3. (b) Social Security Number

578-09-5838

8. AGE: Years 56 Months 7 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace D.C. Washington  
 (Town, county, and state)

10. Usual occupation ENGINEER

11. Industry or business

12. Name THOMAS D. KLEH

13. Birthplace GERMANY

14. Maiden name UNKNOWN

15. Birthplace GERMANY

16. Informant THOMAS R. KLEH

Address 4004 BLADENSBURG RD CITY MD

17. BURIAL Date thereof 12 27 48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory FT. LINCOLN CEMETERY

Location DIST LINE 2 BLADENSBURG RD

18. Funeral director W.W. CHAMBERS CO

Address 5801 - CLEVELAND AVE, RIVERDALE

19. Dec 26, 19 48 Amanda Downey  
 (Date rec'd by registrar) (MD) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 19 48 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/22 1948 to 12/25 1948  
 and that I last saw him alive on 12/25 1948

Immediate cause of death Coronary Rupture infarction DURATION 12/16/48

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Shagor M. D. or other \_\_\_\_\_

Address our hood ind Date signed 12/25/48

RECEIVED

DEC 28 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12742

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Riversdale Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Esperance Island Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4102 Ballaton St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mr. William Harvey Sarge

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Mrs. Mary Ada Sarge (widow)6. (c) If alive, give age 54 years

## 7. Birth date of

deceased (mo., day, yr.)

July 18, 1880

## 8. AGE:

Years

Months

Days

If less than one day

68510

hrs.

min.

## 9. Birthplace

Brooklyn New York  
(Town, county, and state)

## 10. Usual occupation

Brooklyn

## 11. Industry or business

## MOTHER FATHER

## 12. Name

Charles Henry Sarge

## 13. Birthplace

England

## 14. Maiden name

Charlotte Rogers

## 15. Birthplace

New York

## 16. Informant

Mrs. Mary Ada Sarge

## Address

4102 Ballaton St. Hyattsville, Md17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

7-28-48

(month) (day) (year)

## Cemetery or crematory

MT. OLIVET CEMETERY

## Location

WASH. D.C.

## 18. Funeral director

W.W. CHAMBERS Co

## Address

5801 - CLEVELAND AVE. RIVERDALE, MD19. DEC 29

(Date rec'd by registrar)

1948James Leary

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1948 at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 15 1948 to Dec 27 1948and that I last saw him alive on Dec 27 1948

Immediate cause of death

Carcinoma of bladder with metastases

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

RiversdaleDate signed 2-28-48

RECEIVED

DEC 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12743

234  
231

## 1. PLACE OF DEATH:

County Prince George'sCity or town Woodbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

Lower House Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Woodbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. Lower House Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Louise Lusby

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 19, 19408. AGE: Years 8 Months  Days  If less than one day

8. (c) If alive, give age years

9. Birthplace Washington DC  
(Town, county, and state)10. Usual occupation Student

11. Industry or business

12. Name Grover A. Lusby13. Birthplace Maryland14. Maiden name Helen Louise Richardson15. Birthplace Maryland16. Informant Martha RichardsonAddress 7201 - Walbert Mill Rd, Md17. Burial Date thereof 12/28/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Holy TrinityLocation Marlboro, Md.18. Funeral director F. LaGhi SoniAddress Hyattsville, D.C.19. 12/27 19 48 Amanda Dorney  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 19 48 at 8:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19  to 19 and that I last saw h.  alive on 19 Immediate cause of death ShockDue to unrestrained churningburns of entire bodyDue to Other conditions 

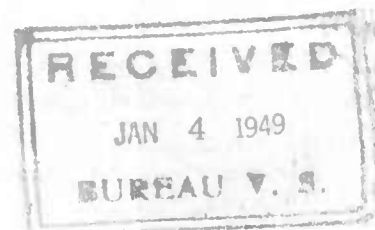
(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-25-48Where did injury occur? Woodbury P.C. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury home that burnedKeely's medical Exam.23. SIGNATURE James E. V. Boyd M. D. or otherAddress Freestonville and Date signed 12-26-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County... Prince Georges  
 City or town... Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr., 4 mos., 5 days  
 Hospital, institution, or street address where death occurred:  
 Glenn Dale Sanatorium  
 How long in hospital or institution? 1 yr., 4 mos., 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... D. C. County...  
 City or town... 1010 Wisconsin Ave., N. W., Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1010 Wisconsin Avenue, N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Thomas Mack

## 3. (b) Social Security Number

577-10-5615

4. Sex Male  
 5. Color or race Negro  
 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife Mr. Charles Mack

7. Birth date of deceased (mo., day, yr.) December 26, 1905  
 8. AGE: Year 42 Month 11 Day 14 If less than one day  
 12 42 11 14 hr. min.

9. Birthplace Culpepper, Virginia  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business - - -

12. Name Thomas Mack

13. Birthplace Jacksonville, Florida

14. Maiden name Sadie Carter Mack

15. Birthplace Culpepper, Virginia

16. Informant Deceased

17. Burial Date thereof Dec 15 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Payne's Cemetery  
 Location Washington, D. C.

18. Funeral director Louis R. Carter

Address 600 - 2<sup>nd</sup> St. S.W.  
 19. Dec. 11, 1948 Rowland S. Philips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 10 1948 at 11<sup>20</sup> a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/4 1947 to 12/10 1948  
 and that I last saw him alive on 12/10 1948

Immediate cause of death Pulmonary Tuberculosis  
 DURATION 3410 9 mos. 8 days

Due to

Due to

Other conditions Tuberculosis Empyema right 14 mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Daniel Lee Duncan MD

Address Glenn Dale, Md. Date signed 12/10/48  
 M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1948

BUREAU 7. 5.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 123-2

## 1. PLACE OF DEATH:

County Prince George's  
City or town Mitchellville, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Joseph Mackall

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Colored Widow  
6. (b) Name of husband or wife Annal Mackall

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE

Years

Months

Days

If less than one day

..... hrs. .... min.

9. Birthplace

Calvert, Co.  
(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

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## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 18

19.

48

at

5:45

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 2 1947 to Dec 18 1948  
and that I last saw him alive on Dec. 17 1948

Immediate cause of death

Coronary Heart Failure

DURATION

2 yrs

Due to

Mitral Stenosis10 yrs

Due to

Arteriosclerosis10 yrs

Other conditions

Secondary Anemia5 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Months of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 12-22-48



RECEIVED

DEC 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince George'sCity or town Spaulding Heights  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 mos

Hospital, institution, or street address where death occurred:

1611-61st Place

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Spaulding  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1611-61st Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Olive Ethel Maxwell

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

James C. Maxwell

## 7. Birth date of deceased (mo., day, yr.)

July 9, 1872

## 6. (c) If alive, give age

78 years

## 8. AGE:

Years

Months

Days

If less than one day

76

hrs.

min.

## 9. Birthplace

Fort Fairfield, Maine  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

Mr. George Gay

## 13. Birthplace

Maine

## MOTHER

## 14. Maiden name

Rose Humphreys

## 15. Birthplace

Maine

## 16. Informant

Helen Lamberton

## Address

1611-61st Ave

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

Dec. 11-1948  
(month) (day) (year)

## Cemetery or crematory

Cedar Hill Cemetery

## Location

Southland, Maryland

## 18. Funeral director

H. H. Edwards Co

## Address

517-15th St SE Wash. DC

## 19.

Dec. 8  
(Date rec'd by registrar)

19

48Carrie Campbell

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

December 8, 1948 at 2:30 P. M.

## 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

## Immediate cause of death

Coronary occlusion

## DURATION

## Due to

Cardiovascular renal disease

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

Reput Medical Examiner  
Thomas D. P. Boyer

or other

## Address

1200 14th St NW

## Date signed

12-8-48

RECEIVED

DEC. 11 1948

BUREAU V. S.

520  
39  
461  
25  
436  
25  
411  
20  
391  
100  
291  
1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 243

## 1. PLACE OF DEATH:

County... Prince Georges Co.

City or town... Glenn Dale, Md. (RURAL)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium

How long in hospital or institution? 3 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... District of Columbia County... -

City or town... Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4310- Royal St., S.E.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

McDERMOTT, MARY THERESA

## 3. (b) Social Security Number

599-20-3625

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 8. (b) Name of husband or wife

James A. McDermott

## 7. Birth date of deceased (mo., day, yr.)

Sept., 15, 1921

## 8. (c) If alive, give age... years

## 8. AGE:

Years

Months

Days

If less than one day

27

3

12

hrs.

min.

## 9. Birthplace

Washington, D. C.

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

## 12. Name

Carl Wm. Flaherty

## 13. Birthplace

Wash., D.C.

MOTHER

## 14. Maiden name

Mary T. Flowers

## 15. Birthplace

Wash., D.C.

## 16. Informant

decedent

## Address

## 17.

removal  
(Burial, cremation, or removal. Which?)

## Date thereof

Dec. 28, 1948  
(month) (day) (year)

## Cemetery or crematory

Washington, D.C.

## Location

Simmons Bros. Funeral Home

## 18. Funeral director

## Address

2007 Nicholas ave, S.E.

## 19.

Dec. 28, 1948  
(Date rec'd by registrar)Rowland S. Phillips  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec. 27, 1948, at 11:10 p.m.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/27, 1948, to 12/27, 1948

and that I last saw her alive on 12/27, 1948

## Immediate cause of death

pulmonary tuberculosis 32 yrs

## DURATION

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

M. D. or other

Address: Glenn Dale, Md. Date signed: 12/27/48

RECEIVED

JAN 5 1949

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12748 245

### 1. PLACE OF DEATH:

County Prince George's  
City or town W. Brentwood, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years  
Hospital, institution, or street address where death occurred:  
4538-41st Avenue

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town W. Brentwood, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4538-41st Avenue  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Mary Ellen McKenzie

### 3. (b) Social Security Number

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife George W. McKenzie  
(deceased) 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 4-26-1876

8. AGE: Years 72 Months 8 Days 3 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Key West, Florida  
(Town, county, and state)

10. Usual occupation Housewife with daughter's retinal

11. Industry or business Housekeeper own home

12. Name James A. Symonette

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown (daughter)

16. Informant Mrs. Ora M. Bullock

Address 4538-41st Ave. N. Brentwood

17. Burial Date thereof 1-1-49  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Lincoln Cemetery

Location Southland Maryland

18. Funeral director Ralph Barber

Address 48-K N.E. WASH. DC

19. Dec 30 1948 James Severy  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1948 at 9:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 29 1948 to Dec. 29 1948

and that I last saw her alive on Dec. 29 1948

Immediate cause of death Myocarditis  
Acute

### DURATION

Aug. 1948

Due to Arterio-Sclerosis 6 mo.

Due to Acute Nephritis 4 mo.

Other conditions psoriasis 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. H. Spiller M. D. or other

Address Brentwood Md. Date signed 12-29-48

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 31 1948

BUREAU P. C.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Murksville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

#7 Bacon Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Murksville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 Bacon Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Katie M<sup>e</sup> Magnus

## 3. (b) Social Security Number

## 4. Sex

F.

## 5. Color or race

C

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Alleshaw M<sup>e</sup> Magnus6. (c) If alive, give age 55 years

## 7. Birth date of

deceased (mo., day, yr.)

June 1, 1917

## 8. AGE:

Years

Months

Days

If less than one day

31

6

9

hrs.

min.

## 9. Birthplace

N. Carolina  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

?

## FATHER

## 12. Name

Marvin A.C.

## 13. Birthplace

?

## MOTHER

## 14. Maiden name

Marvin A.C.

## 15. Birthplace

## 18. Informant

## Address

Alleshaw M<sup>e</sup> Magnus  
Murksville, Maryland.

## 19. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Dec. 14, 1948  
(month) (day) (year)

## Cemetery or crematory

Queens Chapel Cemetery

## Location

Murksville, Md.

## 18. Funeral director

## Address

H.S. Washington & Sons  
467-N St. N.W. Wash., D.C.19. December 16<sup>th</sup> 1948

(Date rec'd by registrar)

John D. Smith  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

December 9, 1948, at 10:00 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death Paste Congestive  
Heart Failure

## DURATION

## Due to

Chronic Bronchial  
Asthma

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

H. John Maloney  
Chesley, Maryland

## Deputy Medical

Examiner

M. D. or other

Date signed 12-9-48

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DEC 15 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **243**

### 1. PLACE OF DEATH:

County **Prince Georges Co.,**  
City or town **Glenn Dale, Md. (rural)**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **5 yrs., 7 mo., 28 days**  
Hospital, institution, or street address where death occurred:  
**Glenn Dale Sanatorium**  
How long in hospital or institution? **same**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **D.C.** County \_\_\_\_\_  
City or town **Washington**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **725- 3rd St., N.W.**  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

**JOHN D. MERCER**

### 3. (b) Social Security Number

**577-24-3735**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **married**

8. (b) Name of husband or wife **not given**  
alive? **alive?** 8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) **October 5, 1886**

8. AGE: Years **62** Months **1** Days **26** If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace **Lumberton, N.C.**  
(Town, county, and state)

10. Usual occupation **packer and crater (Gov't)**

11. Industry or business \_\_\_\_\_

FATHER 12. Name **James Polk Mercer**  
13. Birthplace **Lumberton, N.C.**

MOTHER 14. Maiden name **Mary Singletary**  
15. Birthplace **Lumberton, N.C.**

16. Informant **deceased**

Address \_\_\_\_\_

17. **General tuberculosis, N.C.** Date thereof **12 1 48**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location \_\_\_\_\_

18. Funeral director **J. Wm. Lee's Sons Co.**

Address **300 4th St. N.E.**

19. **12/1/48 Rowland S. Phillips**  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH **Dec. 1 19 48 4:35 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **APR. 3 19 43** to **Dec. 1 19 48**  
and that I last saw him alive on **DEC. 1 19 48**

Immediate cause of death \_\_\_\_\_

**Pulmonary Tuberculosis**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE **Daniel P. Pinckard M.D.** M. D. or other \_\_\_\_\_

Address **Glenn Dale, Md.** Date signed **12/1/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12751  
239

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Lanham  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sara May Merson

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Allie F. Merson

7. Birth date of deceased (mo., day, yr.)

January 12, 1895

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

531029

hrs.

min.

9. Birthplace

Lanham

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

FATHER

12. Name

Wm. B. Hagerman

13. Birthplace

Sykesville, Md

MOTHER

14. Maiden name

Mary Bertha Leonard

15. Birthplace

Hayles Ferry, W. Va.

16. Informant

Beatie H. Riles

Address

2009 Swickland Lane Baltimore

17. Burial, cremation, or removal. Which?

Burial

Date thereof

Dec. 14, 1948  
(month) (day) (year)

Cemetery or crematory

Lanham Cemetery

Location

Lanham, Md

18. Funeral director

Dr. W. H. Donaldson

Address

Lanham, Maryland

19. Date rec'd by registrar

Dec. 14, 1948

19. 48

M. Brashers  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Lanham  
(If outside city or town limits, write RURAL and give nearest town)Street No. 603 4th St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1 - 1948 to Dec 11, 1948and that I last saw him alive on 12/10 19 48

Immediate cause of death

Coronary occlusion

DURATION

1 hr

Due to

Embolism

Due to

myocardial

Other conditions

acute Gastric Ulcer

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Donaldson

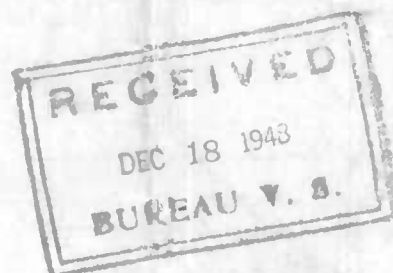
M. D. or other

Address

Lanham

Date signed

12/14/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

830 12752  
Reg. Dist. No. 231

### 1. PLACE OF DEATH:

County Prince George's  
City or town Cheverly  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 14 hours  
Hospital, institution, or street address where death occurred:  
Prince George's General Hospital  
How long in hospital or institution? 14 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George's  
City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 530P - Crittenden St  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Harry J. Miller

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Henrietta Miller  
7. Birth date of deceased (mo., day, yr.) Nov. 29, 1875  
6.(c) If alive, give age years  
8. AGE: Year 73 Months 0 Days 25 If less than one day hrs. min.

9. Birthplace Kentucky  
(Town, county, and state)  
10. Usual occupation Retired  
11. Industry or business Washington sub. conty. Comm.  
12. Name George Miller  
13. Birthplace Germany, Ohio  
14. Maiden name Unknown  
15. Birthplace Germany

16. Informant Erick H. Miller  
Address Hyattsville Md.  
17. Burial Date thereof The 28. 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Evergreen Cemetery  
Location Bladesburg Md  
18. Funeral director F. Gusche, sons  
Address Hyattsville Md  
19. 12/27 1948 Amanda Deane  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1948 at 9:15 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946, to Dec 24 1948  
and that I last saw him alive on Dec 24 1948

Immediate cause of death Cerebral  
accident

Due to  
Due to  
Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Robert W. D.  
Hyattsville, Md M. D. or other  
Address Date signed 12-25-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

DEC 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1700 13253

## 1. PLACE OF DEATH:

County Prince GeorgeCity or town Riverdale  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4408 - Greenbury Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Brentwood  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4520 - 38th St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Thomas Miller

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lola Harte

## 7. Birth date of

deceased (mo., day, yr.) Sept 20, 1873

## 8. AGE:

Years

Months

Days

It less than one day

75

hrs. min.

9. Birthplace North Carolina  
(Town, county, and state)10. Usual occupation Retired from Government

## 11. Industry or business

## MOTHER FATHER

## 12. Name

Jonathan Miller

## 13. Birthplace

North Carolina

## 14. Maiden name

Sarah

## 15. Birthplace

North Carolina

## 16. Informant

Mrs Monty Clarke

## Address

Brentwood Md17. Burial  
(Burial, cremation, or removal. Which?)Date thereof Dec 21, 1948  
(month) (day) (year)

## Cemetary or crematory

Fort Lincoln

## Location

Colmar Manor Md

## 18. Funeral director

F. Groch's sons

## Address

Hyattsville Md19. Dec 21  
(Date rec'd by registrar)

19

48 James Barry

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20, 1948 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death Myocardial infarction

## DURATION

Due to Fracture skull fracture 2 to 3Ruptured pt lungsDue to Secondary hemorrhageOther conditions Comminuted fracture at elbowand fracture  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results (above)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Dec 19, 1948Where did injury occur? Hyattsville Prince George Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Automobile accident Injured at work? no

23. SIGNATURE

J. A. Christensen

M. D. or other

Address College Park Md Date signed 12/19/48

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DEC 22 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12754

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Morningside  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:  
204 Woodland Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George's  
 City or town Morningside  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 204 Woodland Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Alan Mitchell

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Oct 10, 1948  
 8. AGE: Years \_\_\_\_\_ Months 3 Days \_\_\_\_\_ if less than one day  
 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Samuel T. Mitchell

13. Birthplace Mississippi

MOTHER 14. Maiden name Louise O. Clemons

15. Birthplace Washington, D.C.

16. Informant Mr. Louise Mitchell

Address Morningside, Md.

17. Burial (burial, cremation, or removal, Which?) Burial Date thereof Dec 11, 1948  
 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Sutland Md.

18. Funeral director Funeral Home

Address 641 H St. N. E.

19. Dec 10 19 48 Amanda Brown  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 19 48 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

Due to acute congestive heart failure

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work?

Signature James T. Boyd

Address Harstall Date signed 12-10-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:  
 County Prince George  
 City or town Capitol Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 yrs.  
 Hospital, institution, or street address where death occurred:  
819 52nd Avenue  
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Prince George  
 City or town Capitol Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 819 52nd Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

3. (a) FULL NAME George W. Moran

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife Florence E. Moran  
nee Humes 6. (c) If alive, give age 1883 years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 65 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name George Moran

13. Birthplace Washington, D.C.

14. Maiden name Virginia Garrison

15. Birthplace Washington, D.C.

16. Informant Mary E. Taylor

Address 819 52nd Avenue

17. Burial Date thereof Dec. 30/48  
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematorium Washington, D.C.

Location Smithson Park

18. Funeral director Chas. E. Thompson

Address 517 11th St. S.E. Wash. D.C.

19. Dec. 21 19 48 Lennie F. Campbell  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 48 at 2:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death acute congestive heart failure  
cardiovascular disease

Due to cardiovascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury heart failure Injured at work?

23. SIGNATURE James I. D. 30-1 M. D. or other James I. D. 30-1  
 Address Washington, D.C. Date signed 12-29-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948  
65-  
1883





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George Hospital  
 City or town Chesley  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mr. Merle Mingin

7. Birth date of deceased (mo., day, yr.)

Sep 7 12<sup>th</sup> 1887

6. (c) If alive, give age

59 years

8. AGE:

Years

Months

Days

If less than one day

61

hrs.

min.

9. Birthplace

Indiana

(Town, county, and state)

10. Usual occupation

MACHINE OPERATOR

11. Industry or business

FEDERAL WORKS AGENCY

MOTHER FATHER

12. Name

Wm. A. Carr

13. Birthplace

Indiana

14. Maiden name

Margaret Castello

15. Birthplace

Unknown

16. Informant

Mrs. Margaret O'Storman

Address

4004-52nd St. Bladensburg Md.

17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

12-15-48  
(month) (day) (year)

Cemetery or crematory

Oakton Cemetery

Location

Vienna Va.

18. Funeral director

Wm. J. Nalley

Address

3200-R.R. Ave. Mt. Rainier, Md.

19.

(Date rec'd by registrar)

19. 48

Amanda Bourne

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Prince George

City or town

4004-52nd St.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Bladensburg Md

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

15 December 1948 at 9:53 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 9

19 48

to Dec. 15

19 48

and that I last saw her alive on

Dec. 15

19 48

Immediate cause of death

Pulmonary embolism

DURATION

acute

Due to

Coronary occlusion

2 days

Due to

Coronary atherosclerosis

Endite

Other conditions

Thrombus, rt. middle

caval artery

2 days

(Include pregnancy within 3 months of death)

Unknown

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

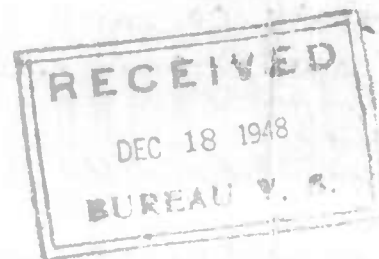
Julius Kueffner, M.D.

M. D. or other

Address

5102 Andrews Rd. Bladensburg Md.

Date signed 12/16/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12757

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Pr. Georges County  
 City or town Capitol Heights Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 daysHospital, institution, or street address where death occurred:  
6120 Bass St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County \_\_\_\_\_City or town Philadelphia  
(If outside city or town limits, write RURAL and give nearest town)Street No. 156 West Tioga St  
(If rural, give LOCATION)

2.(d) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Frank William Nagle

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of ~~husband~~ wife Katherine Nagle7. Birth date of deceased (mo., day, yr.) July 16 1860

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 88 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Philadelphia Pa  
(Town, county, and state)10. Usual occupation Retired Shoemaker11. Industry or business Own shop12. Name Adam Nagle13. Birthplace Germany14. Maiden name ophie (unknown)15. Birthplace Germany16. Informant Mrs. Marie DavisAddress 6120 Bass St Capitol Hgts Md17. Transportation Date thereof Dec 9 1944  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory John O. Neill Funeral HomeLocation Philad Penn.18. Funeral director J. Garcho & SonsAddress Hyattsville Md.19. Dec. 9 1948 Carrie Campbell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1948 at 4:50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 1 1948 to Nov 9 1948  
and that I last saw him alive on Nov 8 1948Immediate cause of death Congestive heart failure DURATION 40 daysDue to arteriosclerotic heart disease } 3 yearsDue to Generalized arteriosclerosisOther conditions uremia 2 weeks  
(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. Suit Ritchie MD  
7005 Ritchie Rd S.E. Wash DC. M. D. or other \_\_\_\_\_Address \_\_\_\_\_ Date signed 12/9/48

RECEIVED

DEC 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12758

245

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Riverdale  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 hrs. 25 min.  
 Hospital, institution, or street address where death occurred:  
Seland Memorial Hosp.  
 How long in hospital or institution? 2 hrs. 25 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince Georges  
 City or town Mount Rainier  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3105 Varnum St.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

Charles Nichols

## 3. (b) Social Security Number

4. Sex m. 5. Color or race W 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Jan 2, 1890  
 8. AGE: Years 68 Months 11 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business

12. Name James W. Nichols  
 13. Birthplace Spartanburg, S.C.  
 14. Maiden name Caroline F. Gulliver  
 15. Birthplace Easton, Md.

16. Informant Florence A. Hewell  
 Address 3105 Varnum St.

17. Burial Date thereof 12-16-48  
 (Burial, cremation, or removal, which) (month) (day) (year)  
 Cemetery or crematory Nichols Methodist Church line  
 Location Adenton, Md.

18. Funeral director J. H. Hunte  
 Address 5732 Ka Ave. Hyattsville

19. Dec 13 1948 James Seay Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1948, at 2:20 P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Crushed right chest - crushed pelvic hemorrhage & shock.  
 Due to fall from roof of building.

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-13-48Where did injury occur? Mt Rainier, P. Geo. Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury fell from roof Injured at work? \_\_\_\_\_23. SIGNATURE John W. Maloney seputy medical examinerAddress Cherry Hill Hyattsville Md. Date signed 12-13-48

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

RECEIVED

DEC 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12759

242

## 1. PLACE OF DEATH:

County Prince George's  
 City or town District Heights, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Years  
 Hospital, institution, or street address where death occurred:  
7310 Foster  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's  
 City or town District Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7310 Foster  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

William Franklin Nichols Jr.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Pearl Mae Nichols  
 6. (c) If alive, give age 44 years  
 7. Birth date of deceased (mo., day, yr.) October 4, 1913  
 8. AGE: Years 35 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Stanley, Oklahoma  
 (Town, county, and state)  
 10. Usual occupation Mechanic  
 11. Industry or business Automobile  
 12. Name William Franklin Nichols Sr.  
 13. Birthplace Oklahoma  
 14. Maiden name Unknown  
 15. Birthplace Oklahoma

16. Informant Pearl M. Nichols  
 Address District Heights, Md.  
 17. Buried Date thereof 12-23-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cedar Hill 12-23-1948  
 Location Landover, Md.  
 18. Funeral director W. D. Chamberlain Co.  
 Address 3072 N. St. Rd.  
 19. Dec 20 19 48 Edna F. Collins  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 19 48 at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Acute congestive heart failure  
 DURATION

Due to Cardiovascular renal disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

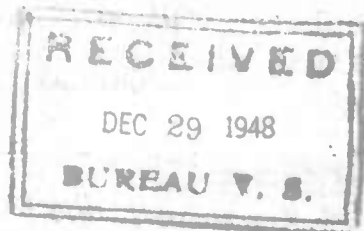
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Deputy Medical Examiner

23. SIGNATURE J. J. [Signature] M. D. or otherAddress Forestville, Md. Date signed 12/20/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Seat Pleasant  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
23 Bellehaven Ave  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George's  
 City or town Seat Pleasant  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 23 Bellehaven Ave  
 (If rural, give LOCATION)  
World War # 1  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Herbert Franklin Parr

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Mary F. Parr

## 7. Birth date of

deceased (mo., day, yr.)

April 24, 18966. (c) If alive, give age 65 years

## 8. AGE:

Years

Months

Days

If less than one day

52

hrs.

min.

## 9. Birthplace

Detroit, Mich.  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

## FATHER

12. Name Harry B. Parr13. Birthplace Michigan

## MOTHER

14. Maiden name Ellen Beatty15. Birthplace Michigan16. Informant Oscar CarricoAddress 5235 5th St. N. W., Washington,

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof Dec 23-1948  
(month) (day) (year)Cemetery or crematory Arlington Nat. CemeteryLocation Arlington Va.

## 18. Funeral director

St. Hines CoAddress 2901-14th St. N. W.

## 19.

Dec 21 19 48 Edward F. Collier  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 19 48 at 9:45p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19 to 19  
 and that I last saw him alive on 19

## Immediate cause of death

Coronary occlusion

## DURATION

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

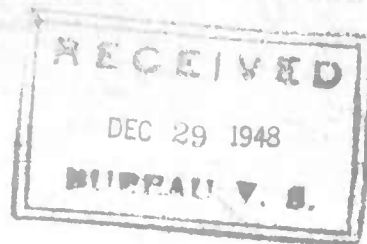
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James S. Boyd M. D. or otherAddress Forestville, Md. Date signed 12/20/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **231**

## 1. PLACE OF DEATH:

County **Prince Georges**  
 City or town **Cheverly**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **1 hour, 25 min.**  
 Hospital, institution, or street address where death occurred:  
**Prince Georges General Hospital**  
 How long in hospital or institution? **1 hour, 25 min.**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Pr. Georges**  
 City or town **Cheverly Manor**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **6318 Kilmer Street**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3.(a) FULL NAME

**Grace Irene Patchen**

## 3.(b) Social Security Number

4. Sex **Female** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Widowed**  
 6.(b) Name of husband or wife **Tom L Patchen**

7. Birth date of deceased (mo., day, yr.) **March 22, 1872**  
 6.(c) If alive, give age ..... years

8. AGE: Years **76** Months **9** Days **9** If less than one day  
 .... hrs. .... min.

9. Birthplace **Ormel, N.Y.**  
 (Town, county, and state)

10. Usual occupation **None**

11. Industry or business

12. Name **James K. Young**  
 13. Birthplace **Unknown**

14. Maiden name **Unknown**  
 15. Birthplace **Unknown**

16. Informant **Esther DuMond**  
 Address **6318 Kilmer Street, Cheverly**

**Manor.**  
 (Burial, cremation, or removal. Which?) Date thereof **Jan 1, 1949**  
 (month) (day) (year)

Cemetery or crematory **Warren**

Location **Penna**

18. Funeral director **F. Kuschel sons**

Address **Hyattsville Md**

19. **Jan 4 1949** **Amanda Woodney**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **December 31** 19 **48** at **8:25 P.** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 ..... 19....., to ..... 19.....  
 and that I last saw h..... alive on ..... 19.....

Immediate cause of death **Acute congestive heart failure.**

Due to **Chronic valvular heart disease**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **John J. Maloney** **Examiner**  
 Address **Cheverly - Hyattsville** M. D. or other

Date signed **12-31-48**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1949

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12762

## CERTIFICATE OF DEATH

Reg. Dist. No. 243.

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Md. (RURAL)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr., 5 mo.'s, 12 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 1 yr., 5 mo.'s, 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County -  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1023- 50th, N.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

JOHN PERRIN

## 3. (b) Social Security Number

577-20-3831

4. Sex male 5. Color or race col. 6. (a) Single, married, widowed, or divorced married  
 8. (b) Name of husband or wife Mattie Perrin  
 8. (c) If alive, give age 34 years  
 7. Birth date of deceased (mo., day, yr.) Aug., 10, 1900  
 8. AGE: Years 48 Months 3 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Greenwood, S. Carolina  
 (Town, county, and state)  
 10. Usual occupation laborer  
 11. Industry or business -  
 FATHER 12. Name Richard Perrin  
 13. Birthplace not known  
 MOTHER 14. Maiden name Liza Mathis  
 15. Birthplace Greenwood, S. Carolina

16. Informant deceased  
 Address \_\_\_\_\_  
 17. Burial Date thereof Dec 11, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Payne's Cemetery  
 Location Washington, D.C.  
 18. Funeral director Henry S. Washington & Sons  
 Address 467 N. St. N.W.  
 19. Dec. 8, 1948 Rowland S. Phillips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 8 1948 at 11 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 26 1947 to DEC 8 1948  
 and that I last saw him alive on DEC 7 1948

Immediate cause of death Pulmonary Tuberculosis  
 DURATION 1 yr. 10 mo.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Daniel Leo Fineman MD  
 M. D. or other \_\_\_\_\_  
 Address Glenn Dale, Md. Date signed 12-8-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12763  
243

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Glenn Dale, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 mos., 17 days  
 Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
 How long in hospital or institution? 6 mos., 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D. C. County Washington  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1010 17th Street, N. E.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war ✓

## 3. (a) FULL NAME

POLANSKY SAMUEL

## 3. (b) Social Security Number

---

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Essie Polansky  
 6. (c) If alive, give age - years  
 7. Birth date of deceased (mo., day, yr.) December 25, 1896  
 8. AGE: Years Months Days If less than one day  
51 51 11 23 hrs. min.

9. Birthplace New York, New York  
 (Town, county, and state)  
 10. Usual occupation Fruit Merchant  
 11. Industry or business ---  
 12. Name Peter Polansky  
 13. Birthplace ? Poland  
 14. Maiden name Did not remember  
 15. Birthplace ? Poland

16. Informant Deceased  
 Address ---  
 17. Burial  
 (Burial, cremation, or removal. Which?) Date thereof Dec 20, 1948  
 (month) (day) (year)  
 Cemetery or crematory Kesler Israel  
 Location Capitol Heights, P.G.C., Md.  
 18. Funeral director B. Danzansky & son  
 Address 3501-14th St NW  
 19. Dec 19, 1948 Howland S. Philips  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 18th 19 48 at 6:30 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20th 19 48 to Dec 18th 19 48  
 and that I last saw him alive on Dec 18th 19 48

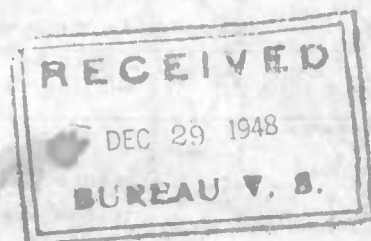
Immediate cause of death Cerebral thrombosis DURATION 2 days  
 Due to Pulmonary Tuberculosis 7 mos  
 Due to Diabetes Mellitus 8 mos  
 Other conditions ---  
 (Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---

Autopsy results ---  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide --- Date of ---  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury --- Injured at work? ---

23. SIGNATURE Daniel Lee Pincus M.D. M. D. or other  
 Address Glenn Dale, Md. Date signed 12/19/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

12764

105

### 1. PLACE OF DEATH:

County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address, where death occurred:  
How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

HARRY MICHAEL PROCTOR

### 3. (b) Social Security Number

4. Sex.....  
5. Color or race.....  
6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....  
6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

8. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal).....

Cemetery or crematorium.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

Registrar.....

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1948, at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to.....

and that I last saw him alive on.....

Immediate cause of death.....

.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

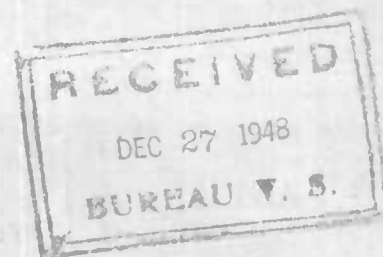
Address.....

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12765

## CERTIFICATE OF DEATH

Reg. Dist. No. 242

## 1. PLACE OF DEATH:

County Prince George'sCity or town Oxon Hill  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 years

Hospital, institution, or street address where death occurred:

5795 St Barnabas Rd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Oxon Hill  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5795 St Barnabas Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Nora Proctor

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Marshall Proctor6. (c) If alive, give age 53 years

## 7. Birth date of

deceased (mo., day, yr.)

## 8. AGE:

Years

Months

Days

If less than one day

35

hrs.

min.

## 9. Birthplace

Maryland  
(Town, county, and State)

## 10. Usual occupation

Housewife

## 11. Industry or business

Own Home

## FATHER

## 12. Name

Joseph Harley

## 13. Birthplace

Shayland

## MOTHER

## 14. Maiden name

Ernest Thompson

## 15. Birthplace

Maryland

## 16. Informant

Marshall Proctor

## Address

Oxon Hill Md

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

12 6 48  
(month) (day) (year)

## Cemetery or crematory

Ignatius Catholic Church

## Location

Open Hill Maryland

## 18. Funeral director

John P. R. Jones & Co.

## Address

901 2nd Street, S.W.

## 19. Loc 4-

(Date rec'd by registrar)

19 48Edna F. Gilman

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec 3 1948 at 11:15 PM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 19 48 to Dec 3 1948and that I last saw her alive on Nov 28 1948

## Immediate cause of death

ToxemiaExhaustionPulmonary tuberculosis

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

James B. Boyd  
M.D. or other  
Address Questrill Rd Date signed 12-3-48

RECEIVED

DEC 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince George

City or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.

City or town Mt. Rainier  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3102 Perry St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

William Frank Reed

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anna May Reed

7. Birth date of

deceased (mo., day, yr.)

September 30, 1870

6. (c) If alive, give age 70 years

8. AGE:

Years

Months

Days

If less than one day

78

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Cashier

11. Industry or business

Press Club

FATHER

12. Name

John J. Reed

13. Birthplace

Virginia

MOTHER

14. Maiden name

Julia Baxter

15. Birthplace

Virginia

16. Informant

Louise Herrmann

Address

3102-Perry St. Mt. Rainier, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 23, 1948

(month) (day) (year)

Cemetery or crematory

Congressional Cemetery

Location

Washington, D.C.

18. Funeral director

Wm. J. Valley

Address

3200 R.I. Ave., Mt. Rainier, Md.

19. Dec 23

(Date rec'd by registrar)

1948

James Serry

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1948 at 7:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 30 1948

to Dec 21 1948

and that I last saw him alive on Dec 20 1948

Immediate cause of death

DURATION

Toxemia

1 week

Due to

Carcinoma of pancreas and sigmoid

Due to

intestine

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

No fixation

Date of op.

Autopsy results

not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. J. Valley

M. D. or other

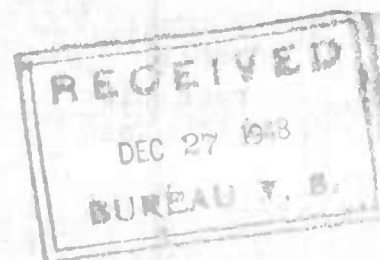
Address

4800-8 St. new

Date signed

Dec 21-48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *265*

### 1. PLACE OF DEATH:

County *Prince Georges*  
City or town *Potomac Md*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *Pronounced on arrival*  
Hospital, institution, or street address where death occurred:  
*Selands Memorial Hospital*  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Washington* County *D.C.*  
City or town *Washington D.C.*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *1924 - Capitol Ave N.E.*  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

*Henry Clinton Sanford*

### 3. (b) Social Security Number

4. Sex *M.* 5. Color or race *C* 6. (a) Single, married, widowed, or divorced *Married*  
6. (b) Name of husband or wife *Bessie Virginia Sanford*  
6. (c) If alive, give age *69* years  
7. Birth date of deceased (mo., day, yr.) *Dec. 29, 1881*  
8. AGE: Years *66* Months *11* Days *15* If less than one day  hrs.  min.

9. Birthplace *Hamilton Va*  
(Town, county, and state)  
10. Usual occupation *Cement finisher*  
11. Industry or business

FATHER: 12. Name *Julius Sanford*  
13. Birthplace *Hamilton Va*  
MOTHER: 14. Maiden name *Margaret*  
15. Birthplace *Hamilton Va*  
16. Informant *Melvin Clinton Sanford*  
Address *1817 Providence St. N.E. Wash DC*  
17. Removal *Dec 13, 1948*  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
Cemetery or crematory *Garne Funeral Home*  
Location *1432 M. ST N.W. Washington D.C.*  
18. Funeral director *F. Gasche Sons*  
Address *Hyattsville Md*  
19. *Dec 13* *44* *James Seery*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 13* 19*48* at *11:30 A*  
21. I CERTIFY that death occurred on the date above stated; that it attended deceased from  to  19  
and that it last saw him  alive on  19

Immediate cause of death *acute congestive heart failure*  
Due to *Coronary artery sclerosis & hypertension*  
Due to *cardio-vascular renal disease*  
Other conditions   
(Include pregnancy within 3 months of death)

Major findings of operations  Date of op.   
Autopsy results *Same*  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  Date of   
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)   
Means of injury  Injured at work?

23. SIGNATURE *John D. Maloney* *deputy*  
Address *Chesley Hyattsville* Date signed *12-13-48*  
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 15 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

61 12768 281  
Reg. Dist. No.

1. PLACE OF DEATH:  
County PRINCE GEORGES  
City or town BLADENSBURG  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 25 YEARS.  
Hospital, institution, or street address where death occurred:  
4910 ANNAPOLIS RD.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MARYLAND County PRINCE GEORGES  
City or town BLADENSBURG  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4910 ANNAPOLIS RD.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

3. (a) FULL NAME LUCY CATHERINE SIMMERS

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced MARRIED.  
6. (b) Name of husband or wife JOHN W. SIMMERS  
6. (c) If alive, give age 85 years  
7. Birth date of deceased (mo., day, yr.) March 20, 1871  
8. AGE: Years 77 Months Days If less than one day  
..... hrs. .... min.

9. Birthplace ROCKINGHAM Co., VA.  
(Town, county, and state)  
10. Usual occupation DOMESTIC  
11. Industry or business  
12. Name unknown  
13. Birthplace VA  
14. Maiden name unknown  
15. Birthplace VA

16. Informant James Simmers  
Address Bladensburg Md.  
17. Burial Date of death Jan 3, 1949  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Linville Cemetery  
Location Linville VA  
18. Funeral director F. Pasch's sons  
Address Hyattsville Md.  
19. Jan 3, 1949 Amanda Donovan Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 31 19 48 at 11:45 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC 26 19 48 to DEC 31 19 48  
and that I last saw her alive on DEC 29 19 48  
Immediate cause of death GANGRENE LEFT FOOT DURATION 2 Mos.  
Due to HYPERTENSIVE - ARTERIO  
SCLEROTIC CARDIO VASC. DISEASE 4 YRS.  
Due to  
Other conditions DIABETES MELLITUS 10 YRS.  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Samuel J. N. Sugar M.D. or other  
Address mt. Rainier, Md. Date signed Jan 1, 1949

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1949

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 12769 243

### 1. PLACE OF DEATH:

County..... Prince Georges  
City or town..... Glenn Dale, Md. (RURAL)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 months, 13 days  
Hospital, institution, or street address where death occurred:  
Glenn Dale Sanatorium  
How long in hospital or institution? 7 months, 13 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....  
City or town..... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1823- Swann St., N.W.  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

### 3. (a) FULL NAME

WILLIE BELL SIMMONS

### 3. (b) Social Security Number

255-34-0293

4. Sex..... female  
5. Color or race..... colored  
6. (a) Single, married, widowed, or divorced..... single

### 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1927

6. (c) If alive, give age..... years

8. AGE: Years 21 Months 9 Days 11 If less than one day..... hrs. .... min.

9. Birthplace..... Mystic, Georgia  
(Town, county, and state)

10. Usual occupation..... bus girl

### 11. Industry or business

12. Name..... Ollie Kinchen  
13. Birthplace..... ?, Georgia

14. Maiden name..... Irene Scott  
15. Birthplace..... ?, Georgia

18. Informant..... deceased

Address

17. Removal Date thereof 12/9/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director

Address 1432- Jan St. N.W.

19. Dec 9, 1948 Rowland S. Phillips  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... DEC. 9 1948, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APR. 26 1948 to DEC. 9 1948 and that I last saw him alive on DEC. 9 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

11 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Daniel Leo Pinicane M.D. Glenn Dale, Md. Date signed 12/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 231

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Chesley, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 days  
 Hospital, institution, or street address where death occurred:  
Prince George's General Hospital  
 How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Prince George's  
 City or town Bladensburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4110 Edmonston Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Smith, David  
 4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sophia Smith

7. Birth date of deceased (mo., day, yr.) February 16, 1872  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
76 yrs.

9. Birthplace England  
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Unk.

13. Birthplace England

14. Maiden name Unk.

15. Birthplace England

16. Informant David Thomas Smith

Address Prince George's Hospital

17. Burial Date thereof 12/24/48  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Switzland, Md.

18. Funeral director W. W. Chambers Co.

Address Riversdale, Md.

19. 12/21 19. 48 Amanda Dourney  
 (Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 20 December 48 at 11:15 P M

21. I CERTIFY that death occurred on the date above stated; that it attended deceased from 12-16- 19. 48, to 12-20 19. 48

and that I last saw him alive on \_\_\_\_\_ 19. \_\_\_\_\_

Immediate cause of death Heart failure DURATION

with Bronchopneumonia

with

Tuberculosis, pulmonary

with

Due to Carcinoma of sigmoid

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. B. ... M. D. or other

Address W. B. ... Date signed 12-21-48

RECEIVED

DEC 27 1948

BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *245*

12771

### 1. PLACE OF DEATH:

County *Prince George's*  
City or town *Greenbelt, Maryland*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *6 hours 36 minutes*  
Hospital, institution, or street address where death occurred:  
*Cigars Island Memorial Hospital*  
How long in hospital or institution? *6 hours 36 minutes*

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Prince George's*  
City or town *Greenbelt, Maryland*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *2 P. Garden Way - Greenbelt, Md.*  
(If rural, give LOCATION)  
2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

*Infant not named Spector*

### 3. (b) Social Security Number

4. Sex *female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *infant*  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) *December 8, 1948*  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. *36* min. *6*

9. Birthplace *Cigars Island Memorial Hospital*  
(Town, county, and state) *Greenbelt, Md.*

10. Usual occupation *Infant*

11. Industry or business \_\_\_\_\_

12. Name *Sidney Aaron Spector*  
13. Birthplace *New York - N.Y.*  
14. Maiden name *Irene Singer*  
15. Birthplace *New York N.Y.*

16. Informant *Mrs. Sidney Aaron Spector mother*

Address *2 P. Garden Way - Greenbelt, Md.*  
17. *Burial* Date thereof *Dec 10, 1948*  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Evergreen*  
Location *Bladensburg Md*

18. Funeral director *E. Spector sons*  
Address *Hyattsville Md.*

19. *Dec 10 1948* James Berry Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 9 1948* at *6 A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Dec. 8 1948* to *Dec. 9 1948*

and that I last saw *her* alive on *Dec. 9 1948*

Immediate cause of death *Prematurity (5 1/2 mos.)* DURATION *6 1/2 hrs.*

Due to *Premature birth*

Due to *?*

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

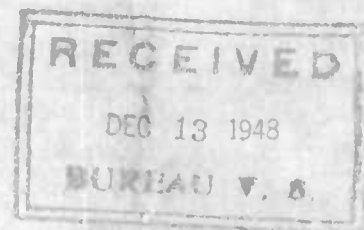
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *William O. Self, M.D.* M. D. or other *Dec. 9, 1948*  
Address *Greenbelt, Md.* Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

158 12772

Reg. Dist. No. 245

## 1. PLACE OF DEATH:

County Prince George's  
City or town Riverdale  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Season annual

Hospital, institution, or street address where death occurred:

Teland Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Suitland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 29 Randall Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Mary Jane Stowe

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Nov 23, 1948

8. AGE:

Years

Months

Days

If less than one day

13

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Wm

11. Industry or business

MOTHER FATHER

12. Name

Edwin Leon Stowe

13. Birthplace

Wash DC

14. Maiden name

Mrs Estelle Linear

15. Birthplace

Wash DC

18. Informant

Address

17. Burial

Date thereof

(Burial, cremation, or removal. Which?)

The 28, 1948  
(month) (day) (year)

Cemetery or crematory

Evergreen

Location

18. Funeral director

Address

19. Dec 29

1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1948, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 to 19

and that I last saw him alive on 19

Immediate cause of death

Malnutrition

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED

DEC 28 1948

BUREAU V. 2.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:  
County Prince Georges  
City or town Branchville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?..

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Prince Georges  
City or town Branchville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 9025--49th Place  
(If rural, give LOCATION)  
World War 1  
2.(a) If veteran, name war

3. (a) FULL NAME  
JOSEPH MONROE TYLER

3. (b) Social Security Number  
None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife xxxx Agnes H. Tyler

6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) January 31st, 1898

8. AGE: Years 50 Months 10 Days 18 If less than one day  
hrs. min.

9. Birthplace Algona, Iowa  
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business U.S. Gov't

12. Name Charles Tyler

13. Birthplace Unknown

14. Maiden name Gertrude Valentine

15. Birthplace Algona, Iowa

16. Informant Agnes H. Tyler

Address 9025-49th Place, Branchville, Md.

17. Burial Dec. 22nd, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington County, Virginia

18. Funeral director W.W. Chambers Company

Address 5801 Cleveland Ave., Riverdale, Md.

19. Dec 19 1948 James S. Searcy

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH 19 December 1948 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Dec 48 and that I last saw him alive on 19 December 1948

Immediate cause of death Coronary Thrombosis DURATION 1 hr

Due to Arteriosclerotic Heart Disease 5-10 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Prof. Etienne

Address Berwyn Ind M. D. or other

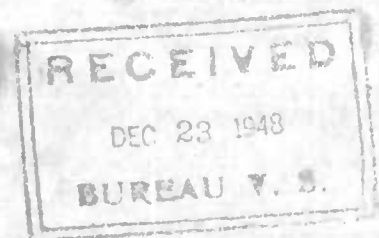
Date signed 12-19-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *73d* *12774* *745*

1. PLACE OF DEATH:  
County *Prince Georges*  
City or town *College Heights*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *37 years*  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State *Maryland* County *Prince Georges*  
City or town *College Heights*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *6809* *Peneway*  
(If rural, give LOCATION)  
2(a) If veteran, name war.

3. (a) FULL NAME *Selen T. Wade*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Married*  
6. (b) Name of husband or wife *Benjamin T. Wade*  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) *April 19, 1870*  
8. AGE: Years *78* Months Days If less than one day  
hrs. min.

9. Birthplace *Nebraska*  
(Town, county, and state)  
10. Usual occupation *Housewife*  
11. Industry or business  
12. Name *Earl S. Thomas*  
13. Birthplace *Illinois*  
14. Maiden name *Clara Church*  
15. Birthplace *Ohio*

16. Informant *Selen Wade Henderson*  
Address *College Heights Md*  
17. *Cremation*  
(Burial, cremation, or removal. Which?) Date interred *Jan 3, 1949*  
(month) (day) (year)  
Cemetery or crematory *Cedar Hill*  
Location *Swittland Md*  
18. Funeral director *F. Paschi sons*  
Address *Hyattsville Md*  
Jan 2 49 James Severy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *December 31, 1948* at *8 P.M.*  
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *March 1948* to *Dec 31, 1948*  
and that I last saw him alive on *12-31-1948*  
Immediate cause of death *Acute Cardiac Dilatation*  
DUE TO *Hypertensive Cardiovascular Disease*  
DUE TO *Noscular Disease*  
Other conditions  
(Include pregnancy within 3 months of death)

DURATION  
*2 hrs*  
*10 yrs*

Major findings of operations.  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE *[Signature]* M. D. or other  
Address *mt. Rainier Md* Date signed *1-4-49*

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

COMMUNICATIONS SECTION

RECEIVED  
JAN 5 1949  
BUREAU T. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.

12775

245

1. PLACE OF DEATH: County <u>Prince Georges</u> City or town <u>Riverdale Md</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>35 years</u> Hospital, institution, or street address where death occurred:  How long in hospital or institution? .....		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md</u> County <u>Prince Georges</u> City or town <u>Riverdale</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>4817 - Nicholson st</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>no</u>	
3. (a) FULL NAME <u>John B. White</u>		3. (b) Social Security Number	
4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>widowed</u>	
6. (b) Name of husband or wife <u>Mary E. White</u>		6. (c) If alive, give age <u>-</u> years	
7. Birth date of deceased (mo., day, yr.) <u>Aug 4, 1871</u>		8. AGE: Years <u>77</u> Months <u>0</u> Days <u>0</u> If less than one day <u>hrs. min.</u>	
9. Birthplace <u>Pa</u> (Town, county, and state)		10. Usual occupation <u>Electrician</u>	
11. Industry or business <u>(retired)</u>		12. Name <u>unknown</u>	
13. Birthplace <u>unknown</u>		14. Maiden name <u>unknown</u>	
15. Birthplace <u>unknown</u>		16. Informant <u>John W. Heisicke</u> Address <u>Riverdale, Md.</u>	
17. Burial <u>Burial</u> Date thereof <u>Dec 16, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year)		18. Funeral director <u>Evergreen</u> Cemetery or crematory <u>Bladenburg Md</u> Location <u>F. Gueche sons</u>	
19. Dec 15 48 James Brown (Date rec'd by registrar)		20. Registrar	
MEDICAL CERTIFICATION			
20. DATE OF DEATH <u>Dec 13, 1948</u> at <u>5:45 A</u>			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Nov. 7, 1948</u> to <u>12-13, 1948</u> and that I last saw him alive on <u>12-12, 1948</u>			
Immediate cause of death <u>Carcinoma of esophagus</u>			
DURATION <u>1 yr</u>			
Due to			
Due to			
Other conditions			
(Include pregnancy within 3 months of death)			
Major findings of operations			
Date of op.			
Autopsy results			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident, suicide, or homicide			
Where did injury occur? (City or town) (County) (State)			
Injured at home, farm, industry, public place (where?)			
Means of injury Injured at work?			
23. SIGNATURE <u>L W. Malin M.D</u> M. D. or other			
Address <u>Riverdale Md</u> Date signed <u>12-15-48</u>			

RECEIVED  
DEC 18 1948  
BUREAU T. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12776

232

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death Transient

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Croom  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war No

## 3. (a) FULL NAME

ANNA ELIZA WILLIAMS

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Henry Williams7. Birth date of deceased (mo., day, yr.) October ?, 18588. AGE: Years Months Days If less than one day  
90 2 ? \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington, D.C.  
(Town, county, and state)10. Usual occupation Social Worker

## 11. Industry or business

12. Name Patrick Taylor13. Birthplace Virginia14. Maiden name Don't know15. Birthplace Don't know16. Informant Mrs. Rachael GallowayAddress 1235 Irving St. NW, Wash. D.C.17. Burial Date thereof Jan. 4, 1949  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Woodlawn CemeteryLocation Washington, D.C.18. Funeral director Thomas ProgieAddress 389 Rhode Island Ave., N.W. Wash, DC19. Jan 1<sup>st</sup> 49 Alfred Smith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Friday, December 31, 48, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_,

and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_\_,

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

acute congestive heart failureDue to Cardiovascular renal disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please overline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James P. Ford M.D. or other \_\_\_\_\_Address 7 destable hwy Date signed 1-31-49



